Within corporate limits

0001

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

331 X 830

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Eckhart — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eckhart
STREET ADDRESS (If rural, give location)

| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) | 4. DATE OF DEATH (Month) (Day) (Year) |
|---|---|
| William Tildon Allen | January 14th 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| male | white | widowed | Nov. 9th 1877 | 71 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired miner | mines | Eckhart, Md | Yes |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Thomas Allen | Delia Patitan |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| no | 214-01-6705 | Francis Allen |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause (a) | Cerebral Vascular Accident | 2 wks |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) | Arteriosclerosis | 6 mo |
| (c) | | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Dec. 14, 1948, to Jan. 14, 1949, that I last saw the deceased alive on Jan. 7, 1949, and that death occurred at 7:15 p.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Arthur F. Jones | M.D. | 1102 S. Centre St. | 1-15-49 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Buried | 1/17/49 | St Michaels Cemetery | Frostburg | Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Jan. 17, 1949 | W.K. Dantz, M.D. | Jacob Hofer, Frostburg, Md. | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 25 1949
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 94a 420.1

0002

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Cumberland, Rural; LENGTH OF STAY (In this place): ; HOSPITAL OR INSTITUTION OR STREET ADDRESS: Valley Road, R.F.D. #3

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Cumberland Md. Allegany Co.; STREET ADDRESS (If rural, give location): Valley Road, R.F.D. #3

3. NAME OF DECEASED (Type or Print): (First) Bert (Middle) Clifford (Last) Appold

4. DATE OF DEATH: (Month) Jan. (Day) 16 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Feb. 14-1887

9. AGE last birthday: 61 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer (retired)

10b. KIND OF BUSINESS OR INDUSTRY: B&O.R.Ry.

11. BIRTHPLACE (State or foreign country): Magnolia W.Va.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Appold

14. MOTHER'S MAIDEN NAME: Mary Gibbs

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY No.:

17. INFORMANT: wife) Mrs. Meady Wagner Appold

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion — Interval Between Onset and Death: about 10 minutes

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary sclerosis also had arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

saw after death

22. I hereby certify that I attended the deceased from 1-16, 1949, to 1-16, 1949, that I last saw the deceased alive on 1-16, 1949, and that death occurred at 6.05 P m., from the causes and on the date stated above.

SIGNATURE H. V. Deming M.D. (Degree or title) ADDRESS DATE SIGNED

Herbert V. Deming M.D. 125 Bedford St. Cumberland Md. 1-17-1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: 1/20/49 | NAME OF CEMETERY OR CREMATORY: Wagoner Cem. | LOCATION (City, town, or county) (State): Dans' Run W. Va.

DATE REC'D BY LOCAL REG.: Jan. 20, 1949 | REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D. | 24. FUNERAL DIRECTOR: H. Wayne George ADDRESS

Deputy Medical Examiner Allegany

RECEIVED
JAN 25 1949
BUREAU V. S.

Within corporate limits

Eleason

EVIDENCE FOR ADDITIONS ITEM # 18 IS ON.

FILM No. G 119 MAR 10 1949

0003

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 94a 420.1

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 630 Elm St

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 630 Elm Street

3. NAME OF DECEASED (Type or Print) (First) ANNIE (Middle) MARGARET (Last) BEYOLKEY

4. DATE OF DEATH (Month) Jan (Day) 26 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Feb 6, 1880
9. AGE last birthday 68 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Cumberland Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME John Küfner
14. MOTHER'S MAIDEN NAME Elizabeth Hartung

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Bernard Beyolkey

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Coronary Occlusion Coronary Artery Disease | 5 yrs |
| Antecedent cause(s) | (b) Intestinal Virus Infection | 4 days |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) Arteriosclerosis [3/9/49 alc] | 5 yrs |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION None
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) No
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 20, 1949, to Jan 26, 1949, that I last saw the deceased alive on Jan 24, 1949, and that death occurred at 9 a m., from the causes and on the date stated above.

SIGNATURE H. W. Eleason (Degree or title) Md
ADDRESS 126 Neuve St Cumberland Md
DATE SIGNED 1/28/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Jan 29, 1949
NAME OF CEMETERY OR CREMATORY St Marys Cemetery
LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REG. Jan. 29, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz M.D.
24. FUNERAL DIRECTOR John J. Hafer
ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 1 1949
BUREAU V. S.

DR. ENFIELD

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1336 601X

## CERTIFICATE OF DEATH

0004

Reg. Diat. No. 4

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 DAYS

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 10 DAYS

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CORRIGANSVILLE
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** MRS. EMMA L. BOWER

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| FEMALE | WHITE | MARRIED |

6.(b) Name of husband or wife WILLIAM A. BOWER

6.(c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) FEBUARY [redacted] 31, 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 10 | 10 | hrs. min. |

9. Birthplace PENNA.
(Town, county, and state)

10. Usual occupation House work

11. Industry or business

FATHER
12. Name HARVEY EMERICK
13. Birthplace PENNA.

MOTHER
14. Maiden name ELIZABETH BURKETT
15. Birthplace PENNA.

16. Informant MEMORIAL HOSPITAL
Address MEMORIAL AVE., CUMBERLAND.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/4/49 (month) (day) (year)

Cemetery or crematory Madley

Location Buffalo Mills Pa RD#1

18. Funeral director Harvey H. Zeigler
Address Hyndman, Pa.

19. Jan. 3 1949 W. L. Lantz M.D. Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH JANUARY 1 1949 at 5:05 PM

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Dec 22 1948 to Jan 1 1949 and that I last saw h[illegible] alive on Jan 1 1949

Immediate cause of death Cerebral Hemorrhage — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation Hypertension Date of op. Dec 22 48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. L. Enfield M. D. or other

Address Cumberland Date signed 1/3/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
JAN 12 1949
BUREAU V. S.

EVIDENCE FOR CHANGE OF BIRTHDATE + AGE ISON:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 97 450.0

0005

FILM No. G 116 FEB -3 1949

# CERTIFICATE OF DEATH

Reg. Dist. No. 10

The correct age

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt Savage; LENGTH OF STAY (in this place) 10 mo.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Foundry row | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pa Garrett; COUNTY Somerset; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Garrett; STREET ADDRESS (If rural, give location) |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) Elizabeth | (Middle) Murray | (Last) Burger | 4. DATE OF DEATH (Month) Jan | (Day) 8 | (Year) 1949 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed | 8. DATE OF BIRTH 9-27-1846 | 9. AGE last birthday 87 yrs. | If under 1 year Months 3 | Days 12 | If under 24 hrs. Hours / Min. |

| | | | |
|---|---|---|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) invalid | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Pa. | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME Daniel Kefer | | 14. MOTHER'S MAIDEN NAME Caroline Ringler | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. none | 17. INFORMANT James Murray |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Pulmonary Embolism - | Nov. 1926 |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Arteriosclerosis. | Probably several years - |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |

| | | | | |
|---|---|---|---|---|
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? | | |

22. I hereby certify that I attended the deceased from March, 1948, to Jan, 1949, that I last saw the deceased alive on Dec. 30, 1948, and that death occurred at 7:35 P. m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| William E. Morley | M.D. | Mt Savage Md | 1-10-1949 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 1-11-49 | Hostetter | Sand Patch, | Pa. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Jan. 10 - 49 | Veronica McDermott | Wm Price, | Meyersdale, Pa. |

VS. A15

RECEIVED
JAN 12 1949
BUREAU U.S.

Within corporate limits

0006

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

490x
108

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital | STREET ADDRESS (If rural, give location) 440 Goethe St. |

3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) Raymond (Last) Burkett. — 4. DATE OF DEATH (Month) Jan (Day) 30 (Year) 1949

5. SEX Male — 6. COLOR OR RACE White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single — 8. DATE OF BIRTH Apr 4 1873 — 9. AGE last birthday 75 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Night Watchman — 10b. KIND OF BUSINESS OR INDUSTRY Footer Dye Works — 11. BIRTHPLACE (State or foreign country) Cumberland Md — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ? Burkett — 14. MOTHER'S MAIDEN NAME Christina Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) — 16. SOCIAL SECURITY NO. 214-05-8598 — 17. INFORMANT Mrs J. H. Stitcher

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Bilateral lobar pneumonia also uremia — about 2 weeks.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes* ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended~~ saw the deceased from 1-31, 1949, to ---------, 19....., that I last saw the deceased ~~alive~~ Dead on 1-31, 1949 and that death occurred at 7.30 A.m. 1-30-49, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland Md. Jan. 31.1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE 2/1/49 — NAME OF CEMETERY OR CREMATORY German Beneficial — LOCATION (City, town, or county) Cumberland, Md (State)

DATE REC'D BY LOCAL REG. February 1, 1949 — REGISTRAR'S SIGNATURE Winter R. Trautz, M.D. — 24. FUNERAL DIRECTOR John J. Hafer - Cumberland, Md — ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 7 1949
BUREAU V. S.

Within corporate limits

Shindler

0007

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 122b 570.5

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 534 Fort Ave., | STREET ADDRESS (If rural, give location) 534 Fort Ave., |

3. NAME OF DECEASED (Type or Print): (First) Virginia (Middle) Trusdale (Last) Burkhart

4. DATE OF DEATH: (Month) Jan. (Day) 21, (Year) 1949

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widowed | Nov. 21, 1867 | 81 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Kitanning, Penna. | U. S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Simon P. Briney | Unknown |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|---|
| No | | None | Mrs. John E. Bennett 534 Fort Ave., |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Intestinal Obstruction — 1 week

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Unknown

(c) Generalized arteriosclerotic Heart Disease Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypertension

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
|---|---|---|
| | | |

| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? | | |

22. I hereby certify that I attended the deceased from Jany, 1917, to Jany 21, 1949, that I last saw the deceased alive on Jany 20, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Blane M. Schindler | Md. | 41 Greenett, Cumberland, Md. | Jany 22, 1949 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Removal | 1/23/49 | Elbert Cem | Elbert, [redacted]. | Colorado |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Jan. 23, 1949 | Winter R. Frantz, M.D. | Charles L. George | Cumberland, Md. |

RECEIVED
FEB 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.2 0008
932

# CERTIFICATE OF DEATH

Reg. Dist. No. 14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ellerslie
LENGTH OF STAY (In this place): 12yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Ellerslie
STREET ADDRESS (If rural, give location):

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Louis | Antoine | Chatain | Jan. | 29 | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widowed | 7/18/1862 | 86 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Cheft | Retired | Baybon, France | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Lewis Chatain | Gauthier Marie |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| | | Alex C. Chatain Ellerslie Md. |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Chronic myocardosis | 20 yrs |
| Antecedent cause(s) | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Jan, 1946, to Jan 29, 1949, that I last saw the deceased alive on Jan 28, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| John A Topper | | Hyndman Pa | |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 2/1/49 | St. Andrews | West Wood N.J. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Jan 31 1949 | J. Lloyd Wolfe | Harvey H. Zeglar | Hyndman, Pa. |

RECEIVED
FEB 3 1949
BUREAU V. S.

0009

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1
93d

# CERTIFICATE OF DEATH

Reg. Dist. No. 5

| | |
|---|---|
| 1. PLACE OF DEATH· COUNTY: Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED· STATE: Maryland COUNTY: Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cresaptown — LENGTH OF STAY (in this place): | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cresaptown |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: Cresaptown School Building | STREET ADDRESS (If rural, give location): |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) Harry | (Middle) Lafayette | (Last) Chilcott | 4. DATE OF DEATH | (Month) January | (Day) 27 | (Year) 1949 |
| 5. SEX: Male | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married | 8. DATE OF BIRTH: 1/11/1884 | 9. AGE last birthday: 65 yrs. | If under 1 year: Months 0, Days 16 | If under 24 hrs.: Hours, Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Janitor | 10b. KIND OF BUSINESS OR INDUSTRY: School Bldg | 11. BIRTHPLACE (State or foreign country): Hyndman, Penna | 12. CITIZEN OF WHAT COUNTRY? U.S. | | | | |
| 13. FATHER'S NAME: Aaron Chilcott | 14. MOTHER'S MAIDEN NAME: Mary Elizabeth Bane | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service) | 16. SOCIAL SECURITY NO.: None | 17. INFORMANT: Mrs Beulah Cunnungham | | | | | |

18. MEDICAL CERTIFICATION

| 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) myocardial Infarction | 15 minutes |
| Antecedent cause(s) | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) coronary Occlusions with repeated myocardial Infarction | 9 mos. |
| | (c) Arteriosclerotic cardiovascular disease | 34. |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION: no | 19b. MAJOR FINDINGS OF OPERATION: no | 20. AUTOPSY? Yes ☐ No ☒ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify): no | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): no (CITY OR TOWN): no (COUNTY) (STATE) | |
| TIME OF INJURY (Month) (Day) (Year) (Hour): no m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? no |

22. I hereby certify that I attended the deceased from July, 1946, to Jan 27, 1949, that I last saw the deceased alive on Jan 13, 1949, and that death occurred at 9:00 A.m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Saville A. Weisman | MD | 122 Bedford St Cumberland | Md |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 1/30/49 | Hill Crest Burial Park | Cumberland | Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1/29/49 | [signature] | William H. Kight | Cumberland, Md. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 4 1949
BUREAU V. S.

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46a 153

0010

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 7 hrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 700 Virginia Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** James M. Conway

**3.(b) Social Security Number** None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Margaret Schellhaus

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 26 1864

**8. AGE:** Years 84 | Months 3 | Days 7 | If less than one day ..... hrs. ..... min.

9. Birthplace: E. Cambridge, Mass.
(Town, county, and state)

10. Usual occupation: Tax Collector

11. Industry or business: City

FATHER
12. Name: James R. Conway
13. Birthplace: Ireland.

MOTHER
14. Maiden name: Ellen Geary
15. Birthplace: Ireland

16. Informant: John L. Conway
Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 5 49 (month) (day) (year)

Cemetery or crematory: St Peter & Pauls Cem

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. Jan. 4, 1949 (Date rec'd by registrar) W.R. Frantz M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 3 1949 at 3 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/5/48 19..., to 1/3 1949

and that I last saw him alive on 1/3/49 19...

Immediate cause of death: Carcinomatosis -

Due to: carcinoma of large bowel.

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE John K. Rozum M. D. or other

Address Cumberland Md Date signed 1/3/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
JAN 12 1949
BUREAU V. S.

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d 443

0611

## CERTIFICATE OF DEATH

Reg. Diat. No. 4

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution? 4 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Penna. County: Bedford
City or town: Buffalo Mills Pa. RD#1
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** Harry Ellsworth Cook

**3.(b) Social Security Number:** Lost

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | W | Married |

6.(b) Name of husband or wife: Edna Rizer Cook
6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): Sept 22 1893

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | 3 | 9 | ...hrs. ...min. |

9. Birthplace: Wellersburg Pa.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:

FATHER
12. Name: Jesse Cook
13. Birthplace: Penna.

MOTHER
14. Maiden name: Belle Long
15. Birthplace: Penna

16. Informant: Edna Cook
Address: Buffalo Mills, Pa..

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/4/49 (month) (day) (year)
Cemetery or crematory: Cooks
Location: Wellersburg, Pa.

18. Funeral director: Harvey. H. Zeigler
Address: Hyndman, Pa.

18. Jan. 3 1949 (Date rec'd by registrar) W. L. Beatty, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/1 1949 at 4.15 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/15 1948, to Jan 1 1949 and that I last saw h. alive on 1/1 1949

Immediate cause of death: Chronic Hypertensive Cardio Vascular Disease — DURATION: 3yr

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John A Topper M.D. M. D. or other
Address: Hyndman R 2 Date signed: Jan 2 1949

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

RECEIVED
JAN 12 1949
BUREAU V. S.

Within corporate limits

DR WEISMAN

0012

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 122b 570.0

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 12HRS 10 MI
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WESTERNPORT
STREET ADDRESS (If rural, give location) 137 MAIN STREET

3. NAME OF DECEASED (Type or Print) (First) SHIRLEY (Middle) C. (Last) CORNETT

4. DATE OF DEATH (Month) JAN. (Day) 22 (Year) 1949

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH NOV. 13 1948

9. AGE last birthday 2-MONTHS If under 1 year Months 2 Days 9 If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) KENTUCKY

12. CITIZEN OF WHAT COUNTRY? AMERICA

13. FATHER'S NAME OSCAR CORNETT

14. MOTHER'S MAIDEN NAME WILMA MAYHEW

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Mr. Oscar Cornett

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) CEREBRAL EDEMA | 24 hours |
| Antecedent cause(s) | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Intussuception Ileo-colic | 1-3 days |
| | (c) Perforated Ulcer of Stomach | 24 hours |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 21, 1949, to Jan 22, 1949, that I last saw the deceased alive on Jan 21, 1949, and that death occurred at 8:00 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Saville G. Weisman M.D. ADDRESS 122 Bedford St, Cumberland DATE SIGNED 1/22/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE Jan. 24, 1949 NAME OF CEMETERY OR CREMATORY Michael Cem. LOCATION (City, town, or county) Firm Rock (State) W. Va.

DATE REC'D BY LOCAL REG. Jan. 23, 1949 REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR E. L. Boal, ADDRESS Westernport, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 1 1949
BUREAU V. S.

Cowgill, W m

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a 331

## CERTIFICATE OF DEATH

0013

Reg. Dist. No. 9

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

**1. PLACE OF DEATH:**
County ~~Garrett~~ Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 Yrs.
Hospital, institution, or street address where death occurred:
Miners Hospital
How long in hospital or institution? 2 Days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County ~~Garrett~~ Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 22 Green St.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** William Beady Cowgill

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6.(b) Name of husband or wife Margaret Casperline
Deceased 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 11, 1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 4 | 13 | hrs. min. |

9. Birthplace Levels, W.Va. (Town, county, and state)
10. Usual occupation B & O Employee
11. Industry or business

FATHER
12. Name Ewing Cowgill
13. Birthplace West Virginia

MOTHER
14. Maiden name Margaret Largent
15. Birthplace West Virginia

16. Informant Edward J. Cowgill
Address 22 Green St. Frostburg - Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 25, 1949 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Cumberland, Md.

18. Funeral director John T Wolford
Address 125 S Liberty St Cumberland Md

19. Jan 25 1949 Mrs Nancy K Roe
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 22 Jan 1949 at 6 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
20 Jan 1949 to 22 Jan 1949
and that I last saw him alive on 22 Jan 1949

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Hemorrhage | |
| Due to Hypertension | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations None Done Date of op.
Autopsy results None Done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J B Davis, MD
M. D. or other
Address Frostburg, Md Date signed 1/22/49.

RECEIVED
JAN 28 1949
BUREAU W. R.

0614

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 83a 331

## CERTIFICATE OF DEATH

Reg. Dist. No. 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Oldtown (rural) — LENGTH OF STAY (In this place) 35 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Oldtown (rural)
STREET ADDRESS (If rural, give location) R.F.D. 1

3. NAME OF DECEASED (Type or Print): (First) GEORGE (Middle) ALBERT (Last) CRAWFORD
4. DATE OF DEATH: (Month) Jan. (Day) 13 (Year) 1949
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify)
8. DATE OF BIRTH: May 20 1880
9. AGE last birthday: 68 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lumber business
10b. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: Michael Crawford
14. MOTHER'S MAIDEN NAME: Eliza J. Smith
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mary E. Watson

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage — 7 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension — 5 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March, 1944, to Jan. 13, 1949, that I last saw the deceased alive on Jan. 9, 1949, and that death occurred at 11:20 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

J. A. Watson M.D. Little Orleans, Md. Jan. 14, 1949

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State)

Burial | January 17, 1949 | Oldtown Cemetery | near Oldtown Md.

DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS

Jan 19. 1949 | Carrie A. Strawhorn | John J. Hofer - Cumberland, Md.

RECEIVED
JAN 21 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0015

434.1

# CERTIFICATE OF DEATH

932 Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 14 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 103 Mary Street

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 103 Mary Street

3. NAME OF DECEASED (Type or Print): (First) Watson (Middle) Leon (Last) Creek

4. DATE OF DEATH: (Month) January (Day) 26 (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: May 1, 1903

9. AGE last birthday: 45 yrs. — If under 1 year: Months. 8 Days 25 — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Refrigeration Engineer

10b. KIND OF BUSINESS OR INDUSTRY: City Ice & Fuel Co

11. BIRTHPLACE (State or foreign country): Piney Grove, Maryland

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Theodore N. Creek

14. MOTHER'S MAIDEN NAME: Anna Creek

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If year, give war or dates of service) 2nd W.W.

16. SOCIAL SECURITY NO.: 217-10-7491

17. INFORMANT: Theodore N. Creek

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Heart Failure, Congestive Acute

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

INTERVAL BETWEEN ONSET AND DEATH: Week

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 14 19 49 to Jan 26 19 49 that I last saw the deceased alive on Jan 26 19 49 and that death occurred at 6 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): W. Rees MD — ADDRESS: 40 Decatur St — DATE SIGNED: 1/27/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: January 29/49 — NAME OF CEMETERY OR CREMATORY: Piney Plaines Cemetery — LOCATION (City, town, or county): (Near) Hancock — (State): Md

DATE REC'D BY LOCAL REG.: Jan. 28, 1949 — REGISTRAR'S SIGNATURE: Winter K. Fantz, M.D.

24. FUNERAL DIRECTOR: William H. Kight — ADDRESS: Cumberland, Md.

VS. A15

RECEIVED
FEB 1 1949
BUREAU V. S.

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1579 756.2

0016

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? One Hour

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? One Hour

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 230 Beall St
(If rural, give LOCATION)

2.(a) If veteran, name war:

**3. (a) FULL NAME**

~~Baby Girl~~ Cross, Mary Lee

**3. (b) Social Security Number**

None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 8 1949

**8. AGE:** Years | Months | Days | If less than one day: One hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Glenn H. Cross
13. Birthplace: Parsons, W. Va.

MOTHER
14. Maiden name: Mary Lee Morehead
15. Birthplace: Cumberland, Md.

16. Informant: Glenn H. Cross

Address: 230 Beall St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1/10/49 (month) (day) (year)

Cemetery or crematory: St Patricks Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Jan. 10, 1949 (Date rec'd by registrar) W.R. Lantz M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: January 8 1949, at 4-05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 8 1949, to January 8 1949 and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Congenital Enlargement of Pulm due to Fibrous Bands — DURATION: ?

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: B. M. Schindler Jr. M.D., or other

Address: 41 Summit Date signed: January 8 1949

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 18 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0017

762.0
161a

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information called for. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 2 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital | 2. USUAL RESIDENCE (HOME) OF DECEASED: (Give usual address) STATE Ohio; COUNTY Columbiana; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN East Liverpool; STREET ADDRESS (If rural, give location) 721 W. Center Lane |

| 3. NAME OF DECEASED (Type or Print) | (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|---|
| | Bruce | Wayne | Dahl | Jan | 30 | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday yrs. | If under 1 year: Months. | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | Jan 28, 1949 | | | 2 days | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Child | | Md. | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Harry C. Dahl | Annie Mae Martin |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| No | None | Harry C Dahl - E. Liverpool, Ohio |

## 18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|
| Immediate cause (a) Asphyxiation (Fetal) | |
| Antecedent cause(s) | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) | |
| (c) Atelectasis Bilateral Congenital | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☑ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 28 Jan, 1949, to 30 Jan, 1949 that I last saw the deceased alive on 30 Jan, 1949, and that death occurred at 7 40 a.m., from the causes and on the date stated above.

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| Luther B. Whitworth M.D. | Cumberland Md | 1/30/49 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 2/1/49 | River View Cemetary | E. Liverpool | Ohio |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Jan 30, 1949 | Winter L. Bantz, M.D. | John J. Hafer - Cumberland Md | |

VS. A15

RECEIVED
FEB 7 1949
BUREAU V. S.

Within corporate limits

0018

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 61

260

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 79-11-19
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 638 N. Mechanic St.

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 638 N. Mechanic St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last): Julius Damm
4. DATE OF DEATH (Month) (Day) (Year): Jan 17 1949

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Jan 28, 1869
9. AGE last birthday: 79 yrs. — If under 1 year: Months, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ~~Street~~ Supt of Sewers
10b. KIND OF BUSINESS OR INDUSTRY: City of Cumberland
11. BIRTHPLACE (State or foreign country): Cumberland Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Damm
14. MOTHER'S MAIDEN NAME: Maria Kuhns

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If year, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs Pearl Palmer Damm

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Diabetic Coma & Softening of Brain — several days

Antecedent cause(s) (b) Diabetes — several years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 1946, to Jan 17, 1949, that I last saw the deceased alive on Jan 14, 1949, and that death occurred at 6.40 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED
F. Alan G. Murray Wm. — La Vale Maryland — 1/19/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: Jan 20 49 — NAME OF CEMETERY OR CREMATORY: Trinity Lath Cem — LOCATION (City, town, or county): Cumberland — (State): Md

DATE REC'D BY LOCAL REG.: Jan. 19, 1949 — REGISTRAR'S SIGNATURE: Winter R. Frantz M.D.
24. FUNERAL DIRECTOR: Louis Stein Inc — ADDRESS: Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 25 1949
BUREAU V. S.

0619

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 93d 420.1

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 22-11-21
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 401 Oldtown Rd.

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Leonard | Leslie | Davis | Jan | 23 | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months. | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Single | Feb. 7 1896 | 52 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Fire tender | Rubber | Cumberland Md. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Ed B Davis | Cora Ivey Valentine |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| | 214-05-7170 | Mrs Ambrose Buckley |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension, Myocarditis

(c) Embemia, Chlolecystitis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) | (Day) | (Year) | (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|---|---|---|
| | | | m. | | |

22. I hereby certify that I attended the deceased from October, 19 48, to Jan 23, 19 49, that I last saw the deceased alive on Jan 23, 19 49, and that death occurred at 4:00 P m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| T Bailey Hunter | MD | Cumberland | 1/24/49 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | Jan 26 49 | Hillcrest Cem | Cumberland | Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Jan. 26, 1949 | W.R. Fautz, M.D. | Lomis Stein Inc | Cumberland |

RECEIVED
FEB 1 1949
BUREAU V. S.

Within corporate limits

0020

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.2
948

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH**
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 23 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 111 South Allegany St.

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 111 South Allegany St.

**3. NAME OF DECEASED** (Type or Print): (First) Thomas (Middle) M. (Last) Davis

**4. DATE OF DEATH**: (Month) Jan. (Day) 28 (Year) 1949

**5. SEX**: male

**6. COLOR OR RACE**: white

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)**: single

**8. DATE OF BIRTH**: July 11 1902

**9. AGE last birthday**: 46 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Stock man

**10b. KIND OF BUSINESS OR INDUSTRY**: Liberty Tavern

**11. BIRTHPLACE** (State or foreign country): Eckhart Md.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Edward Davis

**14. MOTHER'S MAIDEN NAME**: Mary Cordial

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If year, give war or dates of service)

**16. SOCIAL SECURITY NO.**

**17. INFORMANT**: J. Francis Davis —

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Angina pectoris — about 6 weeks

Antecedent cause(s) Arteriosclerosis — ?

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. alcoholic — several years

**19a. DATE OF OPERATION**

**19b. MAJOR FINDINGS OF OPERATION**

**20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended~~ saw the deceased from Jan 28, 1949, to ---------, 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 8.15 P. m., from the causes and on the date stated above.

SIGNATURE: H.V.Deming M.D. (Degree or title) — ADDRESS: Cumberland Md. — DATE SIGNED: Jan.28-1949

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Feb 1, 49 | St. Peter + Paul Cem. | Cumberland Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Jan. 31, 1949 | Minter R. Frantz, M.D. | Louis Stein | Cumberland |

Deputy Registrar

RECEIVED
FEB 7 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0021

561.0

# CERTIFICATE OF DEATH

122a

Reg. Dist. No. 4

| | |
|---|---|
| 1. PLACE OF DEATH COUNTY Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 6 days | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland, |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital | STREET ADDRESS (If rural, give location) 517 Avirett Ave. |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) Jared | (Middle) E. | (Last) Dawson | 4. DATE OF DEATH | (Month) Jan. (Day) 29, (Year) 1949 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed | 8. DATE OF BIRTH 3-19-1860 | 9. AGE last birthday 88 yrs. | If under 1 year Months. Days; If under 24 hrs. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Power Co. Engineer | 10b. KIND OF BUSINESS OR INDUSTRY Edison | 11. BIRTHPLACE (State or foreign country) Dawson, Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S. | | |
| 13. FATHER'S NAME Isaac Dawson | | 14. MOTHER'S MAIDEN NAME Emily Dawson | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT Mr. Edgar Dawson | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Auricular Fibrillation: Myocardial disease | 4 days |
| Antecedent cause(s) | Coronary artery disease | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Strangulated Right inguinal hernia | 6 days |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION 1-24-49 | 19b. MAJOR FINDINGS OF OPERATION Strangulated Rt. inguinal Hernia | 20. AUTOPSY? Yes ☐ No ☒ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from 1-24-49 19....., to 1-30-, 1949, that I last saw the deceased alive on 1-29-, 1949, and that death occurred at 5 35 A m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| C C Zimmerman | M.D. | Cumberland Maryland | 1-31-49 |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE Jan. 31, 49 | NAME OF CEMETERY OR CREMATORY Rose Hill Cem. | LOCATION (City, town, or county) (State) Cumberland, Maryland |
| DATE REC'D BY LOCAL REG. Jan. 31, 1949 | REGISTRAR'S SIGNATURE Winter R. Frantz M.D. | 24. FUNERAL DIRECTOR Charles L. George, | ADDRESS Cumberland, Md. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 7 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

E812,5

0022

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland.; LENGTH OF STAY (in this place) 10 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Robert (Middle) Lee (Last) Day

4. DATE OF DEATH: (Month) Jan. (Day) 18 (Year) 1949

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Aug. 31-1880

9. AGE last birthday: about 68 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Rockingham Co. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unable to secure the information

14. MOTHER'S MAIDEN NAME: Unable to secure the information

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): ?

(If year, give war or dates of service)

16. SOCIAL SECURITY NO.: none 2174477

17. INFORMANT: Different people about town.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Severe concussion of the brain due to being hit by an automobile. — Interval between onset and death: 10 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Ruptured left kidney, retroperitoneal hemorrhage

(c) Fractured 9th&10th ribs left side, posterior.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Empyema left side of chest. Edema of the brain.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): automobile accident

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: route 40 Highway (CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): Jan. 8-49 1.50 A.m.

INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR? Walking on highway, staggered in front of Auto.

22. I hereby certify that I attended the deceased from Jan. 18 19.49, to ----------, 19--, that I last saw the deceased alive on Jan. 18, 19.49, and that death occurred at 6.10 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Deputy Medical Examiner Cumberland Md. Jan. 18-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: Jan. 24, 1949

NAME OF CEMETERY OR CREMATORY: Vale Summitt

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Jan. 22, 1949

REGISTRAR'S SIGNATURE: Write R. Bantz, M.D. Deputy Medical Examiner - Allegany Co.

24. FUNERAL DIRECTOR: Scappelli

ADDRESS: Funeral Home Cumberland

RECEIVED
JAN 25 1949
BUREAU V. S.

Within corporate limits

0023

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 48a 171

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | |
|---|---|
| 1. PLACE OF DEATH · COUNTY: Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 20 Yrs | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: 208 Frederick Street | STREET ADDRESS (If rural, give location): 208 Frederick Street |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) Thelma | (Middle) | (Last) Deetz | 4. DATE OF DEATH | (Month) January (Day) 17 (Year) 1949 |
| 5. SEX: Female | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married | 8. DATE OF BIRTH: May 9 1902 | 9. AGE last birthday: 46 yrs. | If under 1 year: Months 8, Days 8; If under 24 hrs.: Hours, Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House | 10b. KIND OF BUSINESS OR INDUSTRY: House | 11. BIRTHPLACE (State or foreign country): Levells, W. Va. | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME: Edward Haines | 14. MOTHER'S MAIDEN NAME: Catherine Haines | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service) | 16. SOCIAL SECURITY No.: None | 17. INFORMANT: John C. Deetz | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Hemorrhage.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Generalized Carcinomatosis

(c) Carcinoma Cervix

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION: 11-4-46 | 19b. MAJOR FINDINGS OF OPERATION: Annular Metastatic Carcinoma Sigmoid | 20. AUTOPSY? Yes ☐ No ☐ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from 11-4, 1946, to 17 Jan, 1949, that I last saw the deceased alive on 17 Jan, 1949, and that death occurred at 6 A m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Fuller B Mulworth | MD | Cumberland | Md |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify): Burial | DATE: January 20/49 | NAME OF CEMETERY OR CREMATORY: Zion Memorial Park Cemetery | LOCATION (City, town, or county): Cumberland (State): Maryland |
| DATE REC'D BY LOCAL REG.: Jan. 20, 1949 | REGISTRAR'S SIGNATURE: Winter R. Trautz, M.D. | 24. FUNERAL DIRECTOR: William H. Kight | ADDRESS: Cumberland, Mdd. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 25 1949
BUREAU T. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 21

# CERTIFICATE OF DEATH

Reg. Dist. No. 6

Dr. P. R. Wilson 420.1 0025

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barton; LENGTH OF STAY (In this place) 80yrs | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barton |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Utah | STREET ADDRESS Utah (If rural, give location) |

| | | | | |
|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) Hugh Joseph | (Middle) | (Last) Devlin | 4. DATE OF DEATH (Month) Jan (Day) 23 (Year) 1949 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH Feb. 25, 1883 | 9. AGE last birthday 65 yrs. / If under 1 year: Months / Days / If under 24 hrs.: Hours / Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal miner | 10b. KIND OF BUSINESS OR INDUSTRY Coal mine | 11. BIRTHPLACE (State or foreign country) Md. | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Henry devlin | | 14. MOTHER'S MAIDEN NAME Anne Woods | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. 181-10-8087 | 17. INFORMANT Henry D. Devlin | |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|
| Immediate cause (a) Coronary Embolus | Two Hours |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Diseases of Coronary Arteries and Angina Pectoris | One Day |
| (c) | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Acute Appendicitis | One Day |

| | | | | |
|---|---|---|---|---|
| 19a. DATE OF OPERATION None | 19b. MAJOR FINDINGS OF OPERATION — — | | | 20. AUTOPSY? Yes ☐ No ☒ |
| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) None | PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY — | (CITY OR TOWN) — | (COUNTY) — | (STATE) |
| TIME OF INJURY (Month) — (Day) — (Year) — (Hour) — m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ — | HOW DID INJURY OCCUR? — | | |

22. I hereby certify that I attended the deceased from Jan 23, 1949, to Jan. 23, 1949, that I last saw the deceased alive on Jan 23, 1949, and that death occurred at 11:50 A. m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Paul R Wilson M.D. | | Piedmont, W. Va. | Jan. 25, 1949 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Jan. 26, 49 | St. Gabriels Cem. | Barton, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Jan. 26, 1949 | [illegible] M.D. | Ellsworth S. Boal | Westernport, Md |

RECEIVED
JAN 27 1949
BUREAU V. S.

Within corporate limits

Fred Williams

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 83 332

0626

# CERTIFICATE OF DEATH

1454

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany; MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 51 years | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 217 Davidson St. | STREET ADDRESS (If rural, give location) 217 Davidson St. |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| LAURA | Catherine | DIXON | Jan. | 23 | 19 49 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Widow | Oct. 27, 1858 | 90 yrs. | 2 | 26 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | | Petersville, Md. | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James Farrell | Mary Ann Bailey |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|---|
| No | | None | Mrs. Homer C. Brooks |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cerebral Thrombosis | 7 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Generalized Arteriosclerosis | |
| | (c) | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | Infirmities of age. | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☑ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 1-14-, 1949, to 1-23-, 1949, that I last saw the deceased alive on 1-14-, 1949, and that death occurred at about m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Wm. F. Williams Cumberland, Md.

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Jan. 25, 1949 | Mt. Olivet Cemetery | Frederick, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| Jan. 24, 1949 | Lester L. Krantz, M.D. | William H. Kight, Cumberland, Md. |

VS. A15

RECEIVED
FEB 1 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

0624

2411 N. Charles Street, Baltimore 260

# CERTIFICATE OF DEATH 61

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany; MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 35 | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 202 Virginia Ave. | STREET ADDRESS (If rural, give location) 202 Virginia Ave. |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) (Day) (Year) |
|---|---|---|---|
| Charles | E. | Drenning | January I2, 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE Last birthday | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min. |
|---|---|---|---|---|---|---|
| M | W | Married | March I8, I8[illegible]I | 77 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Boilermaker Helper | B&O R.R. | Near Paw Paw, W.Va. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Clark Drenning | Evelyn Jackson |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| No | None | Margaret Drenning |

## 18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Essential Hypertension. | 15 years |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Diabetes Mellitus. | 20 years. |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from June, 1948, to January 12, 1949, that I last saw the deceased alive on January 12, 1949, and that death occurred at 11:30 A m., from the causes and on the date stated above.

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| E. E. Broadrup: M.D. | Cumberland Md. | January 13. 1949. |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | January I5, | I949 St. Mary's Cem. | Cumberland, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Jan. 13. 1949 | M.R. Lantz. M.D. | James F. Scarpelli | Cumberland, Md. |

RECEIVED
JAN 18 1949
BUREAU V. S.

Within corporate limits

Schindler

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95 C 450.0

0027

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 84 yrs.

Hospital, institution, or street address where death occurred: 450 N. Center St.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No.: 450 N. Center St. (If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME:** John George Dreyer

**3. (b) Social Security Number:** 220-10-0138

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed.

6.(b) Name of husband or wife: Anna Eliz. Schaidt.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 26, 1864

**8. AGE:** Years 84 Months 8 Days 19 If less than one day ..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co Md (Town, county, and state)

10. Usual occupation: Foreman Machinist

11. Industry or business: Cumberland Steel Co.

FATHER

12. Name: Frederick Dreyer

13. Birthplace: Germany

MOTHER

14. Maiden name: Margaret Barth

15. Birthplace: Germany.

16. Informant: Edward C. Dreyer

Address: 450 N. Center St Cumb. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 18, 1949 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetery

Location: Cumberland Md.

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. Jan. 18, 1949 (Date rec'd by registrar) Wm. Lantz M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 15 1949, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jany 1 1949, to Jany 15 1949 and that I last saw him alive on Jany 14 1949.

Immediate cause of death: Cardiac Decompensation, Anemia, Fibrillation — DURATION: 2-3 weeks

Due to: Generalized Cataracteristic — Yrs

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: B. M. Schmidt M.D. M.D. or other

Address: 41 Grimes St. Date signed: Jany 18, 1949

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 25 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 170 C 892.5 0028

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH**
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 9 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Pa. COUNTY: Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rockingham
STREET ADDRESS (If rural, give location):

**3. NAME OF DECEASED** (Type or Print): (First) Frank (Middle) (Last) Fatich

**4. DATE OF DEATH**: (Month) Jan. (Day) 24 (Year) 1949

**5. SEX**: male

**6. COLOR OR RACE**: white

**7. SINGLE, MARRIED, WIDOWED, DIVORCED** (Specify): single

**8. DATE OF BIRTH**: Oct. 12-1919

**9. AGE last birthday**: 29 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): miner

**10b. KIND OF BUSINESS OR INDUSTRY**: digging coal

**11. BIRTHPLACE** (State or foreign country): Pa.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Steve Patich

**14. MOTHER'S MAIDEN NAME**: Mary

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If year, give war or dates of service):

**16. SOCIAL SECURITY NO.**: 201-01-7402

**17. INFORMANT**: Hospital chart.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Embolism — at once

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Fractured lumbar vertebraes, due to an Automobile Accident 1-15-49 — 9 days

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
also dislocation of the 2nd. injury to spinal cord.

**19a. DATE OF OPERATION**: 1-17-49

**19b. MAJOR FINDINGS OF OPERATION**: Fracture of the 1st, 2nd, 3rd. 4th. lumbar vertebrae

**20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify): auto. accident

**PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.): Highway Rt. 96 — (CITY OR TOWN): 3miles west of Ellerslie — (COUNTY): Allegany — (STATE): Md.

**TIME OF INJURY** (Month) (Day) (Year) (Hour): Jan. 15/49-4P.m.

**INJURY OCCURRED** While at Work ☐ Not While At work ☒

**HOW DID INJURY OCCUR?**: auto. turned over on a curve, thrown out, caught between auto & roadbed.

22. I hereby certify that I attended the deceased from Jan. 24 1949, to ---------, 19....., that I last saw the deceased ~~alive~~ Dead on Jan. 24, 1949 and that death occurred at 9.15A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Deputy Medical Examiner - Allegany Co. N.V. Deming M.D. — ADDRESS: Cumberland Md. — DATE SIGNED: Jan. 24- 1949

H.V. Deming M.D.

**23. BURIAL, ~~CREMATION~~** (Specify): Burial — **DATE**: 1/30-49 — **NAME OF CEMETERY OR CREMATORY**: Russian Greek Orthodox — **LOCATION** (City, town or county) (State): Central City Pa.

**DATE REC'D BY LOCAL REG.**: Jan. 24, 1949 — **REGISTRAR'S SIGNATURE**: Winter K. Frantz. M.D. — **24. FUNERAL DIRECTOR**: Charles E. Brumbaugh — **ADDRESS**: Central City Pa.

Deputy Medical Examiner - Allegany Co.

RECEIVED
FEB 1 1949
BUREAU OF S.

EVIDENCE FOR CHANGE OF BIRTH DATE SHOWN ON:

FILM No. G 118 JAN 21 1949

0029

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 93d 443

# CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
LENGTH OF STAY (in this place) 58 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Detmold St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural, give location) Detmold Street

3. NAME OF DECEASED (Type or Print) (First) Mary (Middle) Isabel (Last) Fazenbaker

4. DATE OF DEATH (Month) Jan (Day) 8th (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Apr 15 1856
9. AGE last birthday 92 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Henry Speicher
14. MOTHER'S MAIDEN NAME Lavina Metz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT Mrs. Geo. McCormick

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Congestive Heart Failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension — Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION None
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) X
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) X (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) X m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR? X

22. I hereby certify that I attended the deceased from ....., 1948, to 1/8, 1949, that I last saw the deceased alive on 1/8, 1949, and that death occurred at 11 45 A.m., from the causes and on the date stated above.

SIGNATURE Paul Eugene Frye, M.D. (Degree or title) ADDRESS Lonaconing, Md DATE SIGNED 1/10/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Jan 11, 1949
NAME OF CEMETERY OR CREMATORY Philos Cemetery
LOCATION (City, town, or county) Westernport, Md (State)

DATE REC'D BY LOCAL REG. Jan 11, 1949
REGISTRAR'S SIGNATURE Jannette M Boal
24. FUNERAL DIRECTOR M. Eichhorn, Lonaconing, Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 18 1949
BUREAU V. S.

Within corporate limits

DR. R. WMS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

0030

462 153

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 DAYS

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 7 DAYS

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State W.VA. County Mineral

City or town RIDGELEY, W.VA.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 108 MAIN ST.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

**3.(a) FULL NAME**
HENRY H. FILLER

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | W | WIDOWED |

6.(b) Name of husband or wife DOROTHY SHERRARD

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 5-5-84

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 8 | 6 | ..... hrs. ..... min. |

9. Birthplace PA. (Town, county, and state)

10. Usual occupation FOREMAN BRIDGE & BUILDING

11. Industry or business W. MD. R.R.

FATHER
12. Name FLETCHER FILLER
13. Birthplace PA.

MOTHER
14. Maiden name ALICE THOMAS
15. Birthplace PA.

16. Informant MEMORIAL HOSPITAL
Address MEMORIAL AVENUE

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 14, 1949 (month) (day) (year)

Cemetery or crematory Davis Cem.

Location Davis, W. Va.

18. Funeral director Charles L. George
Address Cumberland, Md.

19. Jan. 14, 1949 (Date rec'd by registrar) W.R. Frantz, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 11 1949 at 5:35 pM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct 15 1948 to Jan 11 1949 and that I last saw him alive on Jan 11, 49 19

| Immediate cause of death | DURATION |
|---|---|
| Carcinoma Colon | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma Colon

Date of op. 1/9/49

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M.D. M. D. or other

Address Med Bldg Cumb Md Date signed 1/13/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
JAN 18 1949
BUREAU V. S.

Within corporate limits DR. DURRETT

Evidence for change of age shown on:

MAR 10 6 11 8 JAN 17 1949

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61 343

0031

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 DAYS

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 14 DAYS

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

Street No. 633 N. CENTRE ST., (If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** MR. JOHN L. FISHER

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | MARRIED |

6.(b) Name of husband or wife BLANCHE TWIGG

6.(c) If alive, give age 61 years

7. Birth date of deceased (mo., day, yr.) September 15 1885

**8. AGE:** Years 63 ~~62~~ Months 3 Days 21 If less than one day ..... hrs. ..... min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation SALESMAN

11. Industry or business MONHEIM PRODUCE CO.

FATHER
12. Name WALTER FISHER
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden name EVA RICE
15. Birthplace WEST VIRGINIA

16. Informant MEMORIAL HOSPITAL
Address MEMORIAL AVE.,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/8/49 (month) (day) (year)

Cemetery or crematory Hill Crest Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight
Address Cumberland, Md.

19. Jan. 8, 1949 (Date rec'd by registrar) W.R. Frantz, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 6, 1949 at 12:50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 23 1948 to Jan. 6 1949 and that I last saw him alive on Jan. 5, 1949

Immediate cause of death Encephalitis, non-infectious — DURATION 2 wks

Due to

Due to

Other conditions Diabetes Mellitus - ?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clay E. Durrett M. D. or other

Address Cumberland, Md. Date signed 1/6/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

I

2

RECEIVED
JAN 12 1949
BUREAU V. S.

0632

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 932 1143

## CERTIFICATE OF DEATH

Reg. Dist. No. 10

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage; LENGTH OF STAY (in this place) 40 yrs.; MARYLAND; HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage; STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Anna (Middle) Loretta (Last) Flanigan

4. DATE OF DEATH: (Month) JAN. (Day) 22 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: Nov. 10-1883

9. AGE last birthday: 65 yrs. If under 1 year: Months 2, Days 12, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Frostburg, Md.

12. CITIZEN OF WHAT COUNTRY: United States

13. FATHER'S NAME: Darby J. Bradey

14. MOTHER'S MAIDEN NAME: Marcella Skelley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs Mary William . Mt Savage md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) CHRONIC GLOMERULONEPHRITIS — Interval between onset and death: 5 years or more

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) CHRONIC VASCULAR HYPERTENSION — SEVERAL YEARS

(c) MYOCARDITIS — 6 MONTHS

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. EDEMA, ASCITES & PULMONARY EDEMA.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour): m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1st, 1944, to Jany 22, 1949, that I last saw the deceased alive on Jany. 22, 1949, and that death occurred at 12:20 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

William E. Moseley M. D. January 24th 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: I-25-1949

NAME OF CEMETERY OR CREMATORY: St. Michael's Cemetery

LOCATION (City, town, or county) (State): Frostburg, Allegany, Md

DATE REC'D BY LOCAL REG.: Jan 25/49

REGISTRAR'S SIGNATURE: Veronica McDermott

24. FUNERAL DIRECTOR: Jacob Lafer

ADDRESS: Frostburg, Md.

VS. A15

RECEIVED
JAN 27 1949
BUREAU V. S.

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 938 443

## CERTIFICATE OF DEATH

0633

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs

Hospital, Institution, or street address where death occurred: 717 Glenn St.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 717 Glenn St
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Michael J Fleming

**3. (b) Social Security Number** 220-03-7639

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife Dora E Welch

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 27 1857

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 91 | 3 | 7 | ..... hrs. ..... min. |

9. Birthplace Martinsburg W. Va.
(Town, county, and state)

10. Usual occupation Clerk

11. Industry or business B & O Ry

FATHER 12. Name Thomas Fleming

13. Birthplace Ireland

MOTHER 14. Maiden name Mary E Clark

15. Birthplace Ireland

16. Informant Mrs Edward F Mullen

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 6 49 (month) (day) (year)

Cemetery or crematory Catholic Cem

Location Ferry Hts, W. Va.

18. Funeral director Louis Stein Sons

Address Cumberland

19. Jan 5 1949 (Date rec'd by registrar) C R Lantz M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan 3 1949 at 3 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 18 1948, to Jan 3 1949

and that I last saw h.. alive on Jan 3 1949

| Immediate cause of death | DURATION |
|---|---|
| Uremia | |
| Due to Hypertensive Cardiovascular Disease | |
| Due to Arteriosclerosis | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE George M. Brown M. D. or other

Address 128 Union St. Date signed 1/5/49

RECEIVED
JAN 12 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

443
93d

0034

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 30 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 124 Ormond St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 124 Ormond

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) MRS. MARTHA E. FRESH

4. DATE OF DEATH (Month) (Day) (Year) January 20th 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH 6/2/1877
9. AGE last birthday 71 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
10b. KIND OF BUSINESS OR INDUSTRY home
11. BIRTHPLACE (State or foreign country) Flat Woods, Md.
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME Wm. Alexander
14. MOTHER'S MAIDEN NAME Elizabeth Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs. Pearl Shea, 113 E. Main Frostburg, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Pulmonary edema & ascites — 7 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension heart disease & nephritis — 10 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/3, 1949, to Jan 20, 1949, that I last saw the deceased alive on Jan. 19, 1949, and that death occurred at 7:00 A.m., from the causes and on the date stated above.

SIGNATURE W. E. Hattens (Degree or title) MD ADDRESS Frostburg, Md DATE SIGNED Jan. 21, 49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 1-23-1949
NAME OF CEMETERY OR CREMATORY Allegany
LOCATION (City, town, or county) Frostburg, Md (State)

DATE REC'D BY LOCAL REG. 1-24-49
REGISTRAR'S SIGNATURE Mrs. Nancy H. Roe
24. FUNERAL DIRECTOR Jacob Haper
ADDRESS Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 28 1949
BUREAU [illegible]

Within corporate limits: Yes

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 45 174 0035

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): [illegible]
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Near Cumberland, Rural
STREET ADDRESS (If rural, give location): Bowmans Addition Rt #3

3. NAME OF DECEASED (Type or Print): (First) Ada (Middle) Hazel (Last) Fulk

4. DATE OF DEATH: (Month) January (Day) 22 (Year) 1949 ~~1943~~

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): widowed

8. DATE OF BIRTH: Sept 7, 1903

9. AGE last birthday: 45 yrs. — If under 1 year: Months. Days. Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Criders, Rockingham Co., Va

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Gideon B. Smith

14. MOTHER'S MAIDEN NAME: Amanda Crider

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Robert Nazelrod, Rt #3 Cumb., Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma Uterus (Inoperable) — Interval between onset and death: 6 months

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jany 48, to Jany 22, 1949, that I last saw the deceased alive on Jany 21, 1949, and that death occurred at 1:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Blanche M. Schindler M.D.

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: January 25, 1949 — NAME OF CEMETERY OR CREMATORY: OAK Grove Cemetery — LOCATION (City, town, or county) (State): Good, Rockingham, Va

DATE REC'D BY LOCAL REG.: Jan. 24, 1949 — REGISTRAR'S SIGNATURE: Wister R. Krantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: John D. Hafer, Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M I T

VS. A15

RECEIVED
FEB 1 1949
BUREAU V. S.

Within corporate limits

DR SIMONS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 932 443

0036

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY ALLEGANY, MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND, COUNTY ALLEGANY |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; LENGTH OF STAY (in this place) 25 DAYS | CITY (If outside corporate limits, write RURAL and give nearest town) Near TOWN CUMBERLAND, Rural |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL | STREET ADDRESS (If rural, give location) BOWMANS ADDITION, R.F.D. #3 |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| JAMES | G | GIBBS | JAN. | 24 | 19 49 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | MARRIED | OCT. 10, 1871 | 77 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired | | VA. | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| C.R.GIBBS | CATHERINE PAYNE |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| | None | Mrs. James G. Gibbs |

## 18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cardiac Failure | 6 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertension | 4 years |
| | (c) Myocardial Degeneration | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | Bronchial Asthma | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 1/20, 1949, to 1/24, 1949, that I last saw the deceased alive on 1/24, 1949, and that death occurred at 2:20 A m., from the causes and on the date stated above.

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| George M Simons M.D. | 128 Union Street Cumb. Alley. Md. | |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1-26-1949 | Rose Hill | Hagerstown, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Jan. 26, 1949 | W.L. Trautz, M.D. | Charles L. George | Cumberland, Md. |

VS. A15

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a 420.1

# CERTIFICATE OF DEATH

0037

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

**1. PLACE OF DEATH:**

County Allegany

City or town La Vale Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md County Allegany

City or town La Vale
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** Walter Clyde Gillum

**3.(b) Social Security Number** 214 - 05 - 9979

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | married |

6.(b) Name of husband or wife Mary Miller Gillum

6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Oct. 1- 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 3 | 0 | hrs. min. |

9. Birthplace Bedford Valley Pa.
(Town, county, and state)

10. Usual occupation Calander Dept.

11. Industry or business Kelley Springfield Tire Co.

FATHER 12. Name George Gillum

FATHER 13. Birthplace Bedford Valley Pa.

MOTHER 14. Maiden name Elizabeth Easter

MOTHER 15. Birthplace Beans Cove Pa.

16. Informant Mrs. Mary M. Gillum (wife)

Address LaVale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 4th 1949 (month) (day) (year)

Cemetery or crematory Hillcrest Bur. Park Cem.

Location Cumberland, Md.

18. Funeral director Louis Stein Inc.

Address Cumberland, Md.

19. Jan. 3 1949 (Date rec'd by registrar) W. R. Beantz, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 1 1949 at 4:10 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19... to ... 19...

and that I last saw him alive Dead Jan. 1 1949

| Immediate cause of death | DURATION |
|---|---|
| Coronary occlusion | at once |
| Due to Coronary sclerosis | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.

Autopsy results As Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address Cumberland Md Date signed 12-1-49

RECEIVED
JAN 12 1949
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1 94a

0038

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg; LENGTH OF STAY (in this place): | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg; STREET ADDRESS (If rural, give location): 46 Wright St. |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: 46 Wright St. | |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) (Day) (Year) |
|---|---|---|---|
| HAROLD | | GRINDLE | Jan. 29, 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months. | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | 4-22-1873 | 75 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| laborer | Brickyard | England | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Thomas Grindle | Unknown |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| no | none | Mrs. Harold Grindle |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Coronary Thrombosis | 9 hrs |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Arteriosclerosis | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Jan 29, 1949, to Jan 29, 1949, that I last saw the deceased alive on Jan 29, 1949, and that death occurred at 6 00 P m. from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Wm C Lane | MD | Frostburg Md | Feb 1 1949 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| burial | Feb. 1, 1949 | Allegany Cemetery | Frostburg, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 2-2-49 | Mrs. Nancy H. Roe | J. R. Durst. | Frostburg, Md. |

RECEIVED
FEB 4 1949
BUREAU V. S.

Within corporate limits

0039

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.2
93d

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

A. JONES.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MD.
LENGTH OF STAY (in this place): 85 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: maryland
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: RT. #2 WILLIAMS ROAD,
STREET ADDRESS (If rural, give location): Near CUMBERLAND, MARYLAND

3. NAME OF DECEASED (Type or Print): (First) EDNA (Middle) M (Last) HAGER

4. DATE OF DEATH: (Month) January (Day) 16 (Year) 1949

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

8. DATE OF BIRTH: 8/25/67

9. AGE last birthday: 81 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ARDINGER, [illegible] John

14. MOTHER'S MAIDEN NAME: McDONALD, ALMA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Acute Myocardial Failure | 4 hrs. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Chr. Myocarditis | 3 yrs. |
| | (c) Senility | |

II. OTHER SIGNIFICANT CONDITIONS
Conditiona contributing to the death but not related to tha disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1948 to Jan. 16, 1949, that I last saw the deceased alive on Jan 16, 1949, and that death occurred at 3:50 P.m., from the causes and on the date stated above.

SIGNATURE (Degree or title): Arthur J. Jones M.D.

ADDRESS: 110 S. Centre St.

DATE SIGNED: 1-19-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: 1/19/49

NAME OF CEMETERY OR CREMATORY: Rose Hill

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Jan. 19, 1949

REGISTRAR'S SIGNATURE: Winter K. Fauntz, M.D.

24. FUNERAL DIRECTOR: H. Wayne George

ADDRESS: Cumberland, Md.

RECEIVED
JAN 24 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

824.5

0040

# CERTIFICATE OF DEATH

170c Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (in this place) 7 hrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W.Va.; COUNTY Hardy; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Moorefield; STREET ADDRESS (If rural, give location) |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Blanche | | Hefner | Jan. | 31 | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | white | married | Nov. 7 1906 | 42 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| housewife | [redacted] | Hardy County, W. Va. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Wilbur Crites | Roberta Parsons |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| no | None | Husband) James B. Hefner |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Intracranial hemorrhage | 9 hours |
| Antecedent cause(s) | Fell out of a moving automobile in W.Va. | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Basal fracture of the skull | 9 hours. |
| | (c) abrasions of both knees & left ankle | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒ |
|---|---|---|
| | | |

| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| Auto. accident 1-30-49 | highway | Route 220 - 6 miles South of Moorefield | | W.Va. |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☒ | HOW DID INJURY OCCUR |
|---|---|---|
| Jan. 30-49-3 10 p.m. | | Door of automobile came open & she fell out on highway. |

22. I hereby certify that I saw the deceased from Jan. 31, 1949, to ---------, 19....., that I last saw the deceased alive on Jan. 31, 1949, and that death occurred at 12.15 A.m., from the causes and on the date stated above.

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| H.V. Deming M.D. H.V. Deming M.D. Deputy Medical Examiner - Allegany Co | Cumberland Md. | 1-31-49 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 2 Feb 49 | Scott Cemetery | Hardy County | W.Va |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Jan. 31, 1949 | W.R. Faust M.D. Allegany Co Deputy Medical Examiner | Thrush's | Moorefield. W.Va. |

VS-A15

RECEIVED
FEB 7 1949
BUREAU V. S.

Within corporate limits of Cumberland

0041

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

422.1
93d

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 79 yrs

Hospital, institution, or street address where death occurred: 791 Fayette St.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland. (If outside city or town limits, write RURAL and give nearest town)

Street No. 212 S. Allegany St. (If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** Mrs Elizabeth Hinze

**3.(b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | widowed. |

6.(b) Name of husband or wife Chas W. Hinze.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 6, 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 83 | 1 | 4 | ..... hrs. ..... min. |

9. Birthplace Germany (Town, county, and state)

10. Usual occupation Housewife.

11. Industry or Business

FATHER 12. Name Peter Hoffman

13. Birthplace Germany

MOTHER 14. Maiden name Catherine Krampf

15. Birthplace Germany

16. Informant Mrs. Chas. McTerman

Address 791 Fayette St - Cumberland, Md.

17. Burial Date thereof Jan 13 1949 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hafer.

Address Cumberland Md.

19. Jan 13, 1949 W. L. Fantz M.D. Registrar
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 10, 1949 at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 3 1948 to Jan 10 1949

and that I last saw her alive on Jan 7 1949

| Immediate cause of death | DURATION |
|---|---|
| Chronic Myocardial. | 1 yr. |
| Due to Degeneration | |
| Due to Generalized Arteriosclerosis | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed Jan 12 1949

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JAN 18 1949
BUREAU T. S.

0642

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 52b 181

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg — LENGTH OF STAY (In this place) 75 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 56 Frost Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural, give location) 56 Frost ~~Road~~ Avenue

3. NAME OF DECEASED (Type or Print): (First) MAY (Middle) Frey (Last) Hitchins

4. DATE OF DEATH: (Month) JAN. (Day) 30 (Year) 1949

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec. 17, 1872

9. AGE last birthday: 76 yrs. — If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Adolph Frey

14. MOTHER'S MAIDEN NAME: Anna Hampton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) N

(If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Robert E. Hitchins

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of Bladder — Interval Between Onset and Death: 2 years

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 19 47, to Jan 30, 1949, that I last saw the deceased alive on Jan 27, 1949, and that death occurred at 8:25 A m., from the causes and on the date stated above.

SIGNATURE: Wm Lane MD — (Degree or title) — ADDRESS: Frostburg — DATE SIGNED: Feb 1 1949

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE: Feb. 1, 1949 — NAME OF CEMETERY OR CREMATORY: Allegany Cemetery — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG. 2-2-49 — REGISTRAR'S SIGNATURE: Mrs. Nancy A. Roe — 24. FUNERAL DIRECTOR: J. R. Durst — ADDRESS: Frostburg, Md.

RECEIVED
FEB 4 1949
BUREAU V. S.

Within corporate limits

0643

DR A JONES

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1318 592

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death 6 DAYS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 6 DAYS

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 135 VIRGINIA AVE
(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** BERNARD HODGES

**3.(b) Social Security Number** 705-09-6683

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | MARRIED |

6.(b) Name of husband or wife MILDRED BOWERS

6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) MAY 11, 1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 48 | ~~7~~ | 21 | ..... hrs. ..... min. |

9. Birthplace Grafton W.VA
(Town, county, and state)

10. Usual occupation RETIRED Car Foreman

11. Industry or business B. and O. R.R. Co.

FATHER 12. Name AGUSTA HODGES

13. Birthplace W.VA

MOTHER 14. Maiden name FLORENCE WAGONER

15. Birthplace W.VA

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 5. 1949 (month) (day) (year)

Cemetery or crematory Queen Point Cem.

Location Keyser, W.Va.

18. Funeral director Scarpelli Funeral Home

Address Cumberland, Md.

19. Jan. 4 1949 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH JAN 2 1949 at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1946 to Jan 2 1949 and that I last saw him alive on Jan 2 1949

| Immediate cause of death | DURATION |
|---|---|
| Chronic glomerular nephritis | 8 Mo |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE Arthur J. Jones M.D. M. D. or other

Address 110 S. Centre St. Date signed 1-3-49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
JAN 12 1949
BUREAU V. S.

Within corporate limits

0044

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 124 lb 581.0

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; MARYLAND; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE md; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 101 Park St.

3. NAME OF DECEASED (Type or Print): (First) Nora (Middle) Marie (Last) Jolley

4. DATE OF DEATH: (Month) Jan (Day) 24 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: Apr 8 1882

9. AGE last birthday: 66 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Mt Savage Md.

12. CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME: Michael Kelley

14. MOTHER'S MAIDEN NAME: Sarah Jane Walsh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no

16. SOCIAL SECURITY NO. (If year, give war or dates of service): None

17. INFORMANT: George Jolley

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Transfusion reaction | 12 hrs. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Cirrhosis of the liver | Since Nov., 1947 |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 18 Nov., 19 47, to 24 Jan., 19 49, that I last saw the deceased alive on 24 Jan., 19 49, and that death occurred at 10:00 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

W. Alfred Vance, M.D. Cumberland md 26 Jan. 49

23. BURIAL, CREMATION, REMOVAL, (Specify): Burial

DATE: Jan 27, 1949

NAME OF CEMETERY OR CREMATORY: Sts. Peter & Paul's Cemetery

LOCATION (City, town, or county) (State): Cumberland Md

DATE REC'D BY LOCAL REG.: Jan. 27, 1949

REGISTRAR'S SIGNATURE: Walter L. Bantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: John J. Hafer Cumberland Md

VS. A15

RECEIVED
FEB 1 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 93d 420.0

0045

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully.

I

T

VS. A15

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY: Allegany — STATE: MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (In this place): 70 Years | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: 206 Park Street | STREET ADDRESS (If rural, give location): 206 Park Street |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| Anna | Lee | Keller | January | 14 | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | July 16 1868 | 80 yrs. | 5 | 28 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House | House | Frederick, Maryland | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| James W. Copeland | Rebecca Ellen Myers |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| No | None | George W. Keller |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|
| Immediate cause (a) Acute coronary occlusion | 1/2 hour |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) arteriosclerotic heart disease | 2 yrs. |
| (c) | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | |

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| — | — | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | — |

22. I hereby certify that I attended the deceased from 3-4-; 1947, to 1-14-, 1949, that I last saw the deceased alive on 1-14-; 1949, and that death occurred at 206 Park D. m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| L Phillips | MD | 59 Greene St. | 1-15-49 |

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | January 17/49 | Rose Hill Cemetery | Cumberland, | Maryland |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Jan. 17, 1949 | Walter R. Beauty, M.D. | William H. Kight | Cumberland, Md. |

RECEIVED
JAN 25 1949
BUREAU V. S.

0046

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 174 916.2

# CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH**
COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: In mine, near Westernport
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Eckhart
STREET ADDRESS (If rural, give location):

**3. NAME OF DECEASED** (Type or Print): (First) Fred (Middle) Wm. (Last) Knisley

**4. DATE OF DEATH**: (Month) Jan. (Day) 24 (Year) 1949

**5. SEX**: male

**6. COLOR OR RACE**: white

**7. SINGLE, MARRIED, WIDOWED, DIVORCED** (Specify): married

**8. DATE OF BIRTH**: March 10-1926

**9. AGE last birthday**: 22 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): miner

**10b. KIND OF BUSINESS OR INDUSTRY**: digging coal

**11. BIRTHPLACE** (State or foreign country): Tatesville Pa.

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Elias Knicely

**14. MOTHER'S MAIDEN NAME**: Grace Williams

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): yes
(If year, give war or dates of service): 2

**16. SOCIAL SECURITY NO.**: 220-16-5473

**17. INFORMANT**: Betty Knisley

**18. MEDICAL CERTIFICATION**

**I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH**

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Exsanguination & burns | at once |
| Antecedent cause(s) | Coal mine explosion | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Gaping wounds in neck & chest also left arm upper 3rd. & fracture. Multiple wounds all | |
| | (c) over body. | |

**II. OTHER SIGNIFICANT CONDITIONS**
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION**:

**19b. MAJOR FINDINGS OF OPERATION**:

**20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify): Mine Accident
PLACE (Home, farm, factory, street, office bldg., etc.): In a Coal mine
(CITY OR TOWN): About 2.1/2 Miles north of Westernport
(COUNTY): Allegany
(STATE): Md.

TIME OF INJURY (Month) (Day) (Year) (Hour): Jan. 24 1949 3 p. m.
INJURY OCCURRED While at Work ☒ Not While At work ☐
HOW DID INJURY OCCUR?: Premature explosion

**22.** I hereby certify that I attended the deceased from Jan. 24, 1949, to ----------, 19....., that I last saw the deceased alive on ....., 1949, and that death occurred at about 3 P. m., from the causes and on the date stated above.

SIGNATURE AND (Degree or title): H.V. Deming M.D. H.V. Deming M.D.
ADDRESS: Cumberland Md.
DATE SIGNED: Jan. 24-1949

**23. BURIAL, CREMATION, REMOVAL** (Specify): Burial
DATE: 1/27/49
NAME OF CEMETERY OR CREMATORY: Allegany Cem.
LOCATION (City, town, or county) (State): Frostburg Md.

DATE REC'D BY LOCAL REG.: Jan 26, 1949
REGISTRAR'S SIGNATURE: [illegible]
Deputy Medical Examiner Allegany Co.

**24. FUNERAL DIRECTOR**: Ellsworth S. Broll
ADDRESS: Westernport, Md.

RECEIVED
JAN 27 1949
BUREAU V. S.

Within corporate limits DR SIMONS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 932 448 0047

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. PLEASE WRITE PLAINLY, WITH UNFADING INK.

VS. A15

1. PLACE OF DEATH
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 17 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: MARYLAND
COUNTY: ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
STREET ADDRESS (If rural, give location): 820 GREEN ST.

3. NAME OF DECEASED (Type or Print): (First) DANIEL (Middle) J. (Last) KRAPF

4. DATE OF DEATH: (Month) JAN. (Day) 7 (Year) 19 49

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED

8. DATE OF BIRTH: JULY 29, 1873

9. AGE last birthday: 75 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: ZACHARIAH KRAPF

14. MOTHER'S MAIDEN NAME: DABRA GEIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs. Edward Ewald

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Myocardial Degeneration

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis

(c) Hypertension

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 31, 1948, to Jan 7, 1949, that I last saw the deceased alive on Jan, 1949, and that death occurred at 9:55 A m, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

George M. Simons M.D. 124 Union St Cumb. Md. 1/7/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE: 1/10/49

NAME OF CEMETERY OR CREMATORY: Allegany Cemetery

LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REG.: 1-10-49

REGISTRAR'S SIGNATURE: W.R. Lantz M.D.

24. FUNERAL DIRECTOR: J. R. Durst ADDRESS: Frostburg, Md.

RECEIVED
JAN 18 1949
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 48a 172

0048

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) MARYLAND
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE ~~Maryland~~ Pennsylvania COUNTY ~~Allegany~~ Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN R. D. #3 Cumberland
STREET ADDRESS (If rural, give location) Hazen Rd. near Cumberland

3. NAME OF DECEASED (Type or Print) (First) SUSAN (Middle) LEAH (Last) LEASURE

4. DATE OF DEATH (Month) Jan. (Day) 17, (Year) 1949

5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH 9/29/83 | 9. AGE last birthday 65 yrs. | If under 1 year Months. | Days | If under 24 hrs. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Bedford Valley, Penna.
12. CITIZEN OF WHAT COUNTRY U. S.

13. FATHER'S NAME James Anderson
14. MOTHER'S MAIDEN NAME Napler Beall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs. Herbert D. Hart R. D. #3

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Coronary occlusion | 12 hrs. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertensive cardiovascular Dis. | ? |
| | (c) Adeno carcinoma of uterus. | ? |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | Obesity, marked. | ? |

19a. DATE OF OPERATION 1-11-49
19b. MAJOR FINDINGS OF OPERATION Adenocarcinoma of uterus (fundus)
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-9, 1949, to 1-17, 1949, that I last saw the deceased alive on 1-16, 1949, and that death occurred at 7 35 m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
A. Jamison M.D. 115 S. Centre St. 1/18/49

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE 1/20/49
NAME OF CEMETERY OR CREMATORY Zion Memorial Cem.
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. Jan. 19, 1949
REGISTRAR'S SIGNATURE Wintter K. Lantz, M.D.
24. FUNERAL DIRECTOR ADDRESS Charles L. George Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 25 1949
BUREAU V. S.

Within corporate limits

0049

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 94a 420.1

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 516 N. Mechanic St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 516 N. Mechanic St.

3. NAME OF DECEASED (Type or Print): (First) Richard (Middle) W. (Last) Long

4. DATE OF DEATH: (Month) Jan. (Day) 12, (Year) 1949

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Mar. 24, 1872

9. AGE last birthday: 76 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman

10b. KIND OF BUSINESS OR INDUSTRY: Tire

11. BIRTHPLACE (State or foreign country): Cresaptown, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Reubon A. Long

14. MOTHER'S MAIDEN NAME: Lavenia Stotler

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Sarah Long

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Coronary Disease | 1-2 months |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Generalized arteriosclerosis | years. |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE):

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jany, 1946, to Jany 12, 1949, that I last saw the deceased alive on Jany 11, 1949, and that death occurred at 5:00 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Blanche M. Schindler M.D. 41 Queen St Cumberland, Md Jany 13 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: 1 - 16 -49

NAME OF CEMETERY OR CREMATORY: Forrest Glen

LOCATION (City, town, or county) (State): Green Spring, W. Va.

DATE REC'D BY LOCAL REG.: Jan. 15, 1949

REGISTRAR'S SIGNATURE: Walter R. Beauty, M.D.

24. FUNERAL DIRECTOR ADDRESS: Charles L. George Cumberland, Md.

RECEIVED
JAN 18 1949
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 830 331

0050

# CERTIFICATE OF DEATH

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

**1. PLACE OF DEATH**
COUNTY: Allegany
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport
LENGTH OF STAY (in this place): 55 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 216 Wood Street

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport
STREET ADDRESS (If rural, give location): 216 Wood Street

**3. NAME OF DECEASED (Type or Print)**: (First) SUSAN (Middle) ANN (Last) MATTHEWS

**4. DATE OF DEATH**: (Month) January (Day) 15 (Year) 1949

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)**: Widow

**8. DATE OF BIRTH**: Jan 10, 1861

**9. AGE last birthday**: 88 years

If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

**10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)**: Domestic

**10b. KIND OF BUSINESS OR INDUSTRY**: own home

**11. BIRTHPLACE (State or foreign country)**: Corriganville Md.

**12. CITIZEN OF WHAT COUNTRY?**: USA

**13. FATHER'S NAME**: Samuel Geary

**14. MOTHER'S MAIDEN NAME**: Unknown

**15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)**: No
(If year, give war or dates of service)

**16. SOCIAL SECURITY No.**: None

**17. INFORMANT**: Mr. Harry Matthews

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| **Immediate cause** | (a) Cerebral Hemorrhage - | 2 mo |
| **Antecedent cause(s)** Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertension - | 10 yrs |
| | (c) Arteriosclerosis - | 10 yrs |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Paralitis - 1 wk

**19a. DATE OF OPERATION**

**19b. MAJOR FINDINGS OF OPERATION**

**20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE (Specify)**

**PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY** (CITY OR TOWN) (COUNTY) (STATE)

**TIME OF INJURY** (Month) (Day) (Year) (Hour) m.

**INJURY OCCURRED** While at Work ☐ Not While At work ☐

**HOW DID INJURY OCCUR?**

**22.** I hereby certify that I attended the deceased from Nov. 20, 1948, to Jan 15, 1949, that I last saw the deceased alive on 1/14, 1949, and that death occurred at 3P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H Berry M. D. Piedmont W.Va. 1/15/49

**23. BURIAL, CREMATION REMOVAL (Specify)**: Burial

**DATE**: Jan 17, 1949

**NAME OF CEMETERY OR CREMATORY**: Philos Cemetery

**LOCATION (City, town, or county) (State)**: Westernport, Alle. Md.

**DATE REC'D BY LOCAL REG.**: Jan 17, 1949

**REGISTRAR'S SIGNATURE**

**24. FUNERAL DIRECTOR ADDRESS**: Ellsworth S. Boal, Westernport, Md.

RECEIVED
JAN 18 1949
BUREAU V. S.

Within corporate limits

Hunter or Rozum

0051

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 46d 154

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hosp. | STREET ADDRESS (If rural, give location) R. D. #2 Williams Rd. |

3. NAME OF DECEASED (Type or Print): (First) HAZEL (Middle) LEONA (Last) McDONALD

4. DATE OF DEATH: (Month) Jan. (Day) 19, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec. 2, 1906

9. AGE last birthday: 42 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Green Spring, W. Va.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Burse Malcom

14. MOTHER'S MAIDEN NAME: Ethel Miles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Archie McDonald R.D.#2 Williams Rd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinoma of Rectum

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 1/18/49

19b. MAJOR FINDINGS OF OPERATION: Carcinoma of Rectum

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/15, 1948, to 1/19, 1949, that I last saw the deceased alive on 1/19, 1949, and that death occurred at 6:00 P m., from the causes and on the date stated above.

SIGNATURE: T Bailey Hunter MD (Degree or title) — ADDRESS: Cumberland Md. — DATE SIGNED: 1/21/49

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 1/22/49 — NAME OF CEMETERY OR CREMATORY: Ebenezer Cem. — LOCATION (City, town, or county) (State): Near Romney, W. Va.

DATE REC'D BY LOCAL REG.: Jan. 22, 1949 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D. — 24. FUNERAL DIRECTOR: Charles L. George — ADDRESS: Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 25 1949
BUREAU V. S.

Within corporate limits

Simons

0052

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

331 / 83a

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 638½ Lincoln St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland.
STREET ADDRESS (If rural, give location) 638½ Lincoln St.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) HENRIETTA McDONALD

4. DATE OF DEATH (Month) (Day) (Year) Jan 26 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single
8. DATE OF BIRTH August 23, 1871
9. AGE last birthday 77 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Moscow, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Allen McDonald
14. MOTHER'S MAIDEN NAME Ellen Rattigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT Roger Murray.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Cerebral Vascular Accident | 5 days |
| Antecedent cause(s) | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Hypertension | Unknown |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/21, 1949, to 11/24, 1949, that I last saw the deceased alive on 11/25, 1949, and that death occurred at 11:30 P m., from the causes and on the date stated above.

SIGNATURE George M Simons (Degree or title) M.D. ADDRESS 128 Union St. Cumb. Md. DATE SIGNED 1/28/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Jan 29, 1949
NAME OF CEMETERY OR CREMATORY St Michaels Cath. Cem
LOCATION (City, town, or county) Frostburg Md (State)

DATE REC'D BY LOCAL REG. Jan. 29, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J Hafer - Cumberland Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 1 1949
BUREAU V. S.

Within corporate limits

0053

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.0

# CERTIFICATE OF DEATH

93d Reg. Dist. No. 4

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 60 yrs. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 305 Mt View Drive | STREET ADDRESS (If rural, give location) 305 Mountain V. Drive |

3. NAME OF DECEASED (Type or Print) (First) Nancy (Middle) Mathilda (Last) McGreevy — 4. DATE OF DEATH (Month) Jan (Day) 29 (Year) 1949

5. SEX Female — 6. COLOR OR RACE White — 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Widowed — 8. DATE OF BIRTH May 6, 1870 — 9. AGE last birthday 78 yrs. If under Months. 1 year Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework — 10b. KIND OF BUSINESS OR INDUSTRY at Home. — 11. BIRTHPLACE (State or foreign country) Maryland — 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Dominic A. Arnold. — 14. MOTHER'S MAIDEN NAME Ellen Michael

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) — 16. SOCIAL SECURITY NO. — 17. INFORMANT Bernard McGreevy

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Occlusion — 10 Med.

Antecedent cause(s) (b) Arteriosclerotic Heart Disease

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Generalized Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION None — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January 29, 1949, to Jan. 29, 1949, that I last saw the deceased alive on January 29, 1949, and that death occurred at 10.40 A.m., from the causes and on the date stated above.

SIGNATURE James P. Hallinan (Degree or title) M.D. — ADDRESS Mt. Savage, Maryland — DATE SIGNED January 30, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE Feb 1 49 — NAME OF CEMETERY OR CREMATORY St Gabriel Cem. — LOCATION (City, town, or county) Barton, Md. (State)

DATE REC'D BY LOCAL REG. Jan. 31, 1949 — REGISTRAR'S SIGNATURE Winter R. Lantz M.D. — 24. FUNERAL DIRECTOR Louis Stein Inc. — ADDRESS Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 7 1949
BUREAU V. S.

Within corporate limits

DR. GROVE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 420 420.1 0054

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

T

VS. A15

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; LENGTH OF STAY (in this place) 1 DAY; HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY ALLEGANY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN WESTERNPORT.; STREET ADDRESS (If rural, give location) 307 JOHNSON STREET |

| 3. NAME OF DECEASED (Type or Print) | (First) | (Middle) | (Last) | 4. DATE OF DEATH | (Month) | (Day) | (Year) |
|---|---|---|---|---|---|---|---|
| | THOMAS | A. | MICHAELS | | JAN. | 8 | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| MALE | WHITE | MARRIED | JUNE 19, 1874 | 74 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| RETIRED FARMER | | MARYLAND | |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| JESSE MICHAELS | LIZA JENKINS |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| | | MEMORIAL HOSPITAL |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Coronary occlusion — due | |
| Antecedent cause(s) | to coronary sclerosis | Several years. |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) abscesses of neck. | 4 mos. |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Jan 7, 1949, to Jan 8, 1949, that I last saw the deceased alive on Jan 7, 1949, and that death occurred at 2:05 A. m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| D. R. Grove | M.D. | Medical Bldg Cumberland, Md | 1-8-49 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | January 10, 1949 | Philos | Westernport, Maryland |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Jan. 10, 1949 | Walter K. Fauntz, M.D. | Beals Funeral Home | |

RECEIVED
JAN 18 1949
BUREAU V. S.

Within corporate limits

0055

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 61 260

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 30 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Offutt St. Extended

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) Offutt St. Extended

3. NAME OF DECEASED (Type or Print) (First) Lucy (Middle) Luellen (Last) Miller

4. DATE OF DEATH (Month) Jan. (Day) 17 (Year) 1949

5. SEX Female
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married
8. DATE OF BIRTH Nov. 5-1871
9. AGE last birthday 77 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) W.Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Elijah Rawling
14. MOTHER'S MAIDEN NAME Hester Ann Welch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service)
16. SOCIAL SECURITY NO. —
17. INFORMANT Husband) Micheal Miller

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Diabetes Mellitus | about 40 years |
| Antecedent cause(s) | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased ~~alive~~ Dead on Jan. 17, 1949, and that death occurred at 6.25 A. m., from the causes and on the date stated above.

SIGNATURE H. V. Deming M.D. (Degree or title) ADDRESS DATE SIGNED
Herbert V. Deming M.D. 125 Bedford St. Cumberland Md. Jan. 17-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE January 19, 1949
NAME OF CEMETERY OR CREMATORY Methodist Cemetery
LOCATION (City, town, or county) (State) Vale Summit, Md.

DATE REC'D BY LOCAL REG. Jan. 19, 1949
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR John J. Hofer, Cumberland, Md. ADDRESS

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

T

RECEIVED
JAN 25 1949
BUREAU V. S.

Within corporate limits

A. J.

EVIDENCE FOR CORRECTION OF TIME OF DEATH IS ON FILM #G118, 2-9-49

ALSO ADDITION #3

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

571.1 1203

0056

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY: Allegany — STATE: MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland — COUNTY: Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (in this place): 6 Mo. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: Sylvan Retreat | STREET ADDRESS (If rural, give location): [redacted] 311 Emily Street |

| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) | 4. DATE OF DEATH (Month) (Day) (Year) |
|---|---|
| (Bob) Robert ------ Morgan | Jan. 10, 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months. | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Widowed | May 8, 1870 | 78 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Machinest Helper - Retired | R.R. Co. | London, England | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John Morgan | Eleanor Baxter |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| No | None | Mrs. Elizabeth Wiebel |

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Chronic Entero colitis | 1 Mo |
| Antecedent cause(s) | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from ....., 1946, to Jan 10, 1949, that I last saw the deceased alive on Jan 7, 1949, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Nathan F. Jones | M. D. | 110 S. Centre St. | 1-12-49 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1-12-49 | Rose Hill Cem. | Cumberland, Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Jan. 12, 1949 | Winter R. Frantz, M.D. | Charles L. George | Cumberland, Md. |

VS. A15

RECEIVED
JAN 18 1949
BUREAU F. S.

Outside of City Limits

Dr. Cawley

MARYLAND STATE DEPARTMENT OF HEALTH

0057

2411 N. Charles Street, Baltimore 48a 171

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

I

T

VS. A15

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
LENGTH OF STAY (in this place) 17 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rt. 3, Cumberland, Md

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland
STREET ADDRESS (If rural, give location) Bowman's Addition, R.F.D. #3

3. NAME OF DECEASED (Type or Print): (First) Jessaline (Middle) Mary (Last) Mort

4. DATE OF DEATH: (Month) January (Day) 21 (Year) 1949

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 8, 1897

9. AGE last birthday: 51 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Cresaptown, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Oliver Clevenger

14. MOTHER'S MAIDEN NAME: Pleasant Roby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If year, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Alonza Mort

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma Cervix — Interval Between Onset and Death: 9 Mos.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 3, 1948, to Jan 21, 1949, that I last saw the deceased alive on Jan 3, 1949, and that death occurred at 1:15 A m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Frank Cawley M.D. Memorial Hospital Cumberland Md. Jan 22/49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: January 23, 1949
NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
LOCATION (City, town, or county) (State): near Hancock Md

DATE REC'D BY LOCAL REG.: Jan. 23, 1949
REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR: John J. Hafer ADDRESS: Cumberland, Md.

RECEIVED
FEB 1 1949
BUREAU V. S.

0658

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

113 527.1

Reg. Dist. No. 14

**1. PLACE OF DEATH:**

County: Allegany

City or town: Ellerslie
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Ellerslie
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

**3. (a) FULL NAME:** Ray Winfield Mull

**3. (b) Social Security Number:** 213- 12- 9285

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Francis Zimmerman Mull

6.(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): 2/ 20/ 1920

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 28 | 10 | 18 | ...hrs. ...min. |

9. Birthplace: Ellerslie Maryland
(Town, county, and state)

10. Usual occupation: Celanese

11. Industry or business: Textile

FATHER
12. Name: A.D.Mull
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Margaret Leydig
15. Birthplace: Pennsylvania

16. Informant: Mrs. Francis Mull

Address: Ellerslie Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/11/49 (month) (day) (year)

Cemetery or crematory: Madley

Location: Madley Pa.

18. Funeral director: Harvey H. Zeigler

Address: Hyndman, Pa.

19. Jan 11 1949 (Date rec'd by registrar) J Lloyd Wolfe Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: January 8th 1949, at 2 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1948, to Jan 8 1949

and that I last saw him alive on Jan 8 1949

| Immediate cause of death | DURATION |
|---|---|
| Coronary Thrombosis | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ...Injured at work?

23. SIGNATURE: John A Topper MD M. D. or other

Address: Hyndman Pa. Date signed 1.10.49

M

I

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 13 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 94a

420.1

0059

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eckhart
LENGTH OF STAY (in this place) 50 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS R. D. No I Frostburg, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eckhart
STREET ADDRESS (If rural, give location) R. D. No I Frostburg, Md.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Jesse Stuart Myers

4. DATE OF DEATH (Month) (Day) (Year) I-I9-I949 19

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH 7-IO-I886
9. AGE last birthday 62 yrs. If under 1 year: Months 6, Days 9; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shovel Operator
10b. KIND OF BUSINESS OR INDUSTRY County Rd. Dept.
11. BIRTHPLACE (State or foreign country) Greenspring, W. Va.
12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME Wassen Oliver Myers
14. MOTHER'S MAIDEN NAME Elsie Starliper

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs. Oliver B. Porter

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Coronary Thrombosis | 5 Days |
| Antecedent cause(s) | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 15, 1949, to Jan 19, 1949, that I last saw the deceased alive on Jan 19, 1949, and that death occurred at 2:15 P m., from the causes and on the date stated above.

SIGNATURE W O McLane (Degree or title) MD ADDRESS Frostburg Md DATE SIGNED 1-20-49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE I-2I-I949
NAME OF CEMETERY OR CREMATORY Eckhart Cemetery
LOCATION (City, town, or county) (State) Eckhart, Allegany, Md.

DATE REC'D BY LOCAL REG. 1-25-49
REGISTRAR'S SIGNATURE Mr. Nancy H Roe
24. FUNERAL DIRECTOR Jacob Hafer ADDRESS Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 28 1949
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

0660

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland; HOSPITAL OR INSTITUTION OR STREET ADDRESS Savage Rd, Green Pt.; MARYLAND; LENGTH OF STAY (in this place)

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural Cumberland; STREET ADDRESS (If rural, give location) St Savage Rd., Green Pt.

| 3. NAME OF DECEASED (Type or Print) | (First) | (Middle) | (Last) | 4. DATE OF DEATH | (Month) | (Day) | (Year) |
|---|---|---|---|---|---|---|---|
| | John | A. | Wierman | | Jan | 28 | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months. | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Jan 14 1899 | 50 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Jeweler | Jewelery | Hagerstown Md | U.S.A. |

13. FATHER'S NAME: Augustus Wierman

14. MOTHER'S MAIDEN NAME: Daisy Frey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War I

16. SOCIAL SECURITY NO.:

17. INFORMANT: Elizabeth Burkey Wierman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of lung — Interval between onset and death:

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Metastasis to brain

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Above diagnosis made by X-ray of chest

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☑ |

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-10-, 1948, to 1-28-, 1949, that I last saw the deceased alive on 1-23-, 1949, and that death occurred at 1 a m., from the causes and on the date stated above.

SIGNATURE (Degree or title) W. F. Williams — ADDRESS Cumberland — DATE SIGNED 1-28-'49

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Jan 31 49 | St Peter & Pauls Cem | Cumberland Md. |

| DATE REC'D BY LOCAL REG | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Jan 30 49 | Walter R. Frantz, M.D. | Louis Stein Son | Cumberland |

RECEIVED
FEB 7 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 93d 241

# CERTIFICATE OF DEATH

Reg. Dist. No. 6

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport — LENGTH OF STAY (in this place) 40 yrs | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS 410 Vine Street | STREET ADDRESS (If rural, give location) 410 Vine Street |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) Charles | (Middle) Franklin | (Last) Ordner | 4. DATE OF DEATH | (Month) January (Day) 14 (Year) 1949 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married | 8. DATE OF BIRTH Oct 9, 1884 | 9. AGE last birthday 64 yrs. | If under 1 year Months. Days; If under 24 hrs. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | 10b. KIND OF BUSINESS OR INDUSTRY Railroad | 11. BIRTHPLACE (State or foreign country) Hyndman, Bedford Co, Pa. | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME John Ordner | | 14. MOTHER'S MAIDEN NAME Elizabeth Hetzell | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | (If year, give war or dates of service) | 16. SOCIAL SECURITY No. 705-09-7496 | 17. INFORMANT Marshall Ordner | | |

18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Myocardial Degeneration | 8 mo |
| Antecedent cause(s) | (b) Bronchial Asthma | 12 yrs |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (c) | |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | Arterio Sclerosis | 4 yrs |

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from July, 1948, to Jan 14, 1949, that I last saw the deceased alive on Jan 13, 1949, and that death occurred at 5 9 m., from the causes and on the date stated above.

SIGNATURE James H. Wolcott Jr MD (Degree or title) ADDRESS Seidenstein Wy DATE SIGNED 1/15 49

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE Jan 16, 1949 | NAME OF CEMETERY OR CREMATORY Philos Cemetery | LOCATION (City, town, or county) (State) Westernport, Maryland |
| DATE REC'D BY LOCAL REG. Jan 16, 1949 | REGISTRAR'S SIGNATURE [illegible] MD | 24. FUNERAL DIRECTOR Ellsworth S. Boal, Westernport, Md. | ADDRESS |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 15 1949
BUREAU V. S.

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

151 H6b 0062

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH**
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): One Day
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: West Virginia — COUNTY: Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Elk Garden
STREET ADDRESS (If rural, give location):

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| George | Daniel | Parrish | Jan. | 20, | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Sept. 19, 1878 | 70 yrs. | 4 | 1 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Coal Miner | Coal Mines | Doddridge Co. W. Va. | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| John A. Parrish | Eliza Jane McNemar |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| No | 216-01-4837 | Otha F. Sharpless |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Gastric Hemorrhage | ? |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Carcinoma Stomach | 1 yr? |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| None | — | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| — | — | — | — | — |

| TIME OF INJURY (Month) | (Day) | (Year) | (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|---|---|---|
| — | — | — | m. | | — |

22. I hereby certify that I attended the deceased from 1-19-49, 19—, to 1-20, 19—, that I last saw the deceased alive on 1-19-49, 19—, and that death occurred at 3:50 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

C. A. Zimmerman M.D. Cumberland, Md.

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Jan. 23, 1949 | I.O.O.F. Cemetery | Elk Garden, W. Va. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR ADDRESS |
|---|---|---|
| Jan. 21, 1949 | Wister R. Fantz M.D. | O. F. Sharpless, Elk Garden, W. Va. |

RECEIVED
JAN 25 1949
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

290.0

0063

# CERTIFICATE OF DEATH 430 Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place) 1 week; HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; STREET ADDRESS (If rural, give location) 87 Broadway

3. NAME OF DECEASED (Type or Print): (First) Sarah (Middle) Eleanor (Last) Pascoe

4. DATE OF DEATH: (Month) 1 (Day) 27 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 9-27-1882

9. AGE last birthday: 66 yrs. If under 1 year: Months; Days 8. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Baston Md

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: John M. Smyth

14. MOTHER'S MAIDEN NAME: Eliza Kennedy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)

(If year, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Mr. Robert Pascoe

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pernicious Anaemia — Interval Between Onset and Death: 8 years

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1940 19..., to Jan 27, 1949, that I last saw the deceased alive on Jan 26, 1949, and that death occurred at 9:40 A m, from the causes and on the date stated above.

SIGNATURE: Wm C Lane (Degree or title) M D — ADDRESS: Frostburg Md — DATE SIGNED: Jan 28 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 1-29-1949 — NAME OF CEMETERY OR CREMATORY: Allegany — LOCATION (City, town, or county): Frostburg, Alley. Md. (State)

DATE REC'D BY LOCAL REG.: 1-29-49 — REGISTRAR'S SIGNATURE: Mrs. Nancy N. Rose

24. FUNERAL DIRECTOR: Jacob Harper — ADDRESS: Frostburg, Md

VS. A15

RECEIVED
FEB 1 1949
BUREAU V. S.

Within corporate limits

DR. TOPPER

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 61

## CERTIFICATE OF DEATH 260

0064

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND; LENGTH OF STAY (in this place) 19 HRS.; HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE [illegible] Maryland; COUNTY ALLEGANY; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ELLERSLIE; STREET ADDRESS (If rural, give location)

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| HANNAH | E | PORTER | Jan | 18 | 19 49 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months. | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| FEMALE | WHITE | MARRIED | JUNE 29, 1882 | 66 yrs. | | | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housefife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): PENN

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: JOHN BEAL

14. MOTHER'S MAIDEN NAME: NANCY BENNETT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Stephen D. Porter Stephen D. Porter

### 18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Diabetes Mellitus | 10 yrs. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) acidosis | 2 dys. |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| — | — | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| — | — | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | — | — |

22. I hereby certify that I attended the deceased from Jan, 1949, to Jan 18, 1949, that I last saw the deceased alive on Jan 19, 1949, and that death occurred at 1 35 A m., from the causes and on the date stated above.

SIGNATURE: John A Topper (Degree or title) ADDRESS: Hyndman Pa DATE SIGNED: 1/20/49.

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1/21/49 | Porter | Hyndman, Pa. RD#1 |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Jan. 20, 1949 | W. R. Fautz, M.D. | Harvey H. Zigler | Hyndman, Pa |

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
JAN 25 1949
BUREAU V. S.

Within corporate limits

M

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0065

# CERTIFICATE OF DEATH

422.1

61 Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (In this place) 42 hrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Nikep
STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print) (First) Bridget (Middle) Veronica C. (Last) Rafferty

4. DATE OF DEATH (Month) (Day) (Year) January 19th 1949

5. SEX Female

6. COLOR OR RACE White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH Feb 14 1880

9. AGE last birthday 68 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework

10b. KIND OF BUSINESS OR INDUSTRY Own home

11. BIRTHPLACE (State or foreign country) Moscow Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME James Condon

14. MOTHER'S MAIDEN NAME Anna Monahon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If year, give war or dates of service) ✓

16. SOCIAL SECURITY NO. ✓

17. INFORMANT Mrs Clatterback

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Myocarditis with auricular fibrillation and cardiac failure, cause undetermined. | ? |
| Antecedent cause(s) | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Diabetes mellitus | ? |
| | (c) Generalized arteriosclerosis | ? |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 19, 1949, to ....., 19....., that I last saw the deceased alive on Jan. 19, ....., 1949, and that death occurred at 11:30 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) W. Alfred Van Ormer, M.D. ADDRESS 110 S. Centre St., Cumb., Md. DATE SIGNED Jan. 21, 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE Jan. 22 1949 NAME OF CEMETERY OR CREMATORY St Gabriels Cemetery LOCATION (City, town, or county) Boarton (State) Md.

DATE REC'D BY LOCAL REG. 1-21-49 REGISTRAR'S SIGNATURE Winter R. Frantz M.D. 24. FUNERAL DIRECTOR M. Eichhorn, Lonaconing Md ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

T

VS. A15

RECEIVED
JAN 25 1949
BUREAU V. S.

0066

916.2

174

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN In a mine near Westernport
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Hampshire Hill

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) Kenneth (Middle) Brown (Last) Riggleman

4. DATE OF DEATH (Month) Jan. (Day) 24 (Year) 1949

5. SEX male
6. COLOR OR RACE white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married
8. DATE OF BIRTH March 31-1915
9. AGE last birthday 33 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) miner
10b. KIND OF BUSINESS OR INDUSTRY Coal mine
11. BIRTHPLACE (State or foreign country) Westernport Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Wilber Riggleman
14. MOTHER'S MAIDEN NAME Minnie Lambert

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If year, give war or dates of service) 2
16. SOCIAL SECURITY NO. 214-16-2364
17. INFORMANT Leo Riggleman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Exsanguination & Burns | at once |
| Antecedent cause(s) | Coal mine Explosion | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Head, both lower legs & left hand blown off, Multiple wounds all over body. | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) mine accident
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY in a coal mine
(CITY OR TOWN) about 2.1/2 miles north of Westernport (COUNTY) Allegany (STATE) Md.
TIME OF INJURY (Month) (Day) (Year) (Hour) 1-24-49-3 P. m.
INJURY OCCURRED While at Work ☒ Not While At work ☐
HOW DID INJURY OCCUR? Premature explosion.

22. I hereby certify that I ~~attended~~ saw the deceased ~~from~~ 1-24, 1949 to -------, 19....., that I last saw the deceased ~~alive~~ Dead on 1-24-, 1949 and that death occurred at about 3 P.m., from the causes and on the date stated above.

SIGNATURE H.V. Deming M.D. (Degree or title) H.V. Deming M.D. ADDRESS Cumberland Md. DATE SIGNED Jan. 24- 1949

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE 1/27/49
NAME OF CEMETERY OR CREMATORY Philos Cem
LOCATION (City, town, or county) Westernport (State) Md

DATE REC'D BY LOCAL REG. Jan. 26. 1949
REGISTRAR'S SIGNATURE [signature]
24. FUNERAL DIRECTOR Ellsworth S. Boal ADDRESS Westernport, Md.

Deputy Medical Examiner Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 27 1949
BUREAU V. S.

Within corporate limits: Barrett.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

420.1 / 94a

0667

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 38 Browning St.

How long in hospital or Institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 38 Browning St.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME:** Everhart Harvey Robertson

**3. (b) Social Security Number:** 214-05-9046

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Laura V. Gulbronson

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): March 26, 1875.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | | | hrs. min. |

9. Birthplace: Kifer, Allegany Co. Md. (Town, county and state)

10. Usual occupation: Laborer

11. Industry or business: Celanese Corp.

FATHER

12. Name: Samuel Robertson

13. Birthplace

MOTHER

14. Maiden name: Christina Lechliter

15. Birthplace: Mineral Co. W. Va.

19. Informant: Frank Robertson

Address: 164 N. Mechanic St Cumb.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 20 1949 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland Md.

19. Funeral director: John J. Hafer

Address: Cumberland Md.

19. Jan 18 1949 (Date rec'd by registrar) A.R. Fauntz M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Jan 17 1949 at 1:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 17 1949 to Jan. 18 1949 and that I last saw him alive on Jan. 17. 1949

| Immediate cause of death | DURATION |
|---|---|
| Coronary Thrombosis | 6 hrs |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Clay R. Lucas M. D. or other

Address: Cumberland Date signed: 1/18/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

RECEIVED
JAN 25 1949
BUREAU V. S.

Within corporate limits

0668

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1
93d

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

T

VS. A15

**1. PLACE OF DEATH**
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) MARYLAND 50 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 311 Schley St

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 311 Schley St.

**3. NAME OF DECEASED** (Type or Print): (First) Richard (Middle) D. (Last) Robertson

**4. DATE OF DEATH**: (Month) Jan (Day) 26 (Year) 1949

**5. SEX**: Male

**6. COLOR OR RACE**: White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)**: Married

**8. DATE OF BIRTH**: Nov 11 1866

**9. AGE** last birthday: 82 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Boiler Inspr. Retired

**10b. KIND OF BUSINESS OR INDUSTRY**: Railway

**11. BIRTHPLACE** (State or foreign country): Green Ridge Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Samuel Robertson

**14. MOTHER'S MAIDEN NAME**: Christine Fuchsiter

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If year, give war or dates of service):

**16. SOCIAL SECURITY NO.**: None

**17. INFORMANT**: Sarah Slider Robertson (wife)

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Hypocardial Degeneration — Interval Between Onset and Death: 1-24-48

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary Arteriosclerosis — 1-26-49

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION**:

**19b. MAJOR FINDINGS OF OPERATION**:

**20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT SUICIDE HOMICIDE** (Specify):

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-24-1948, to 1-26-1949, that I last saw the deceased alive on 1-25-1949, and that death occurred at 7:40 A.m., from the causes and on the date stated above.

SIGNATURE AND (Degree or title): W. F. Williams ADDRESS: Cumberland DATE SIGNED: 1-26-49

**23. BURIAL, CREMATION REMOVAL** (Specify): Burial DATE: Jan 28 '49 NAME OF CEMETERY OR CREMATORY: Rose Hill Cem. LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REG.: Jan. 28, 1949 REGISTRAR'S SIGNATURE: Winter L. Hartz, M.D.

**24. FUNERAL DIRECTOR**: Lowes & Hess Inc. ADDRESS: Cumberland

RECEIVED
FEB 1 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

592
131

0069

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ~~Luke~~ Luke
LENGTH OF STAY in this place: 8 3 Yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Luke Md.
STREET ADDRESS (If rural, give location) 150 Pratt St.

3. NAME OF DECEASED (Type or Print): (First) Mary (Middle) Ann (Last) Sanders
4. DATE OF DEATH: (Month) Jan. (Day) 18 (Year) 19 49

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single
8. DATE OF BIRTH: Sept 29, 1865
9. AGE last birthday: 83 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House-work
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Brithish Lle, Eng.
12. CITIZEN OF WHAT COUNTRY: U.S.

13. FATHER'S NAME: James Sanders
14. MOTHER'S MAIDEN NAME: Anna Mallen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service): No
16. SOCIAL SECURITY No.: None
17. INFORMANT: Frances Sanders Hickman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Uremia (coma) | one Day |
| Antecedent cause(s) | Chronic Myoperditis Not Specified as | Six Months |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Rheumatic | |
| | (c) Chronic Nephritis | One Year |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): None
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 3, 1946, to Jan. 18, 1949, that I last saw the deceased alive on Jan. 18, 1949, and that death occurred at 11:05 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED
Paul R. Wilson M.D. | Piedmont, W. Va. | Jan. 19, 1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: Jan 21, 49.
NAME OF CEMETERY OR CREMATORY: Holy Sepulchre
LOCATION (City, town, or county) (State): Paterson, N.J.

DATE REC'D BY LOCAL REG.: Jan. 19, 1949
REGISTRAR'S SIGNATURE: [illegible]
24. FUNERAL DIRECTOR: Ellsworth S. Boal-Westernport, Md.
ADDRESS

RECEIVED
JAN 20 1949
BUREAU V. S.

Outside of City Limits

M

0070

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1
93d

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany — Narrows Park — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland Rural — LENGTH OF STAY (in this place) 42 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS R.F.D. #6, Narrows Park

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland Rural
STREET ADDRESS (If rural, give location) R.F.D. #6 ~~R. 40 Mt. Pike~~, Narrows Park

3. NAME OF DECEASED (Type or Print) (First) Edgar (Middle) Harrison (Last) Seem

4. DATE OF DEATH (Month) January (Day) 29 (Year) 1949

5. SEX Male — 6. COLOR OR RACE White — 7. ~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~DIVORCED~~, (Specify) married — 8. DATE OF BIRTH Feb 26 1878 — 9. AGE last birthday 70 yrs. — If under 1 year: Months 11, Days — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Engineer — 10b. KIND OF BUSINESS OR INDUSTRY Silk Mill — 11. BIRTHPLACE (State or foreign country) Bethlehem Pennsa — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Andrew Seem — 14. MOTHER'S MAIDEN NAME Carolina Strauch

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If year, give war or dates of service) — 16. SOCIAL SECURITY NO. 214-05-5435 — 17. INFORMANT Mrs Emma R. Seem Wife

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Thrombosis — Instant

Antecedent cause(s) (b) Chronic Myocarditis — several years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION none — 19b. MAJOR FINDINGS OF OPERATION none — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1947, to Jan 29, 1949, that I last saw the deceased alive on Jan 20, 1949, and that death occurred at 5:55 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) F. Alan G. Murray M.D. — ADDRESS 41 Green St Cumberland Md — DATE SIGNED Jan 31/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE Feb 1, 1949 — NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery — LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REG. Feb. 1, 1949 — REGISTRAR'S SIGNATURE Walter R. Frantz, M.D. — 24. FUNERAL DIRECTOR John C. Wel Lord — ADDRESS Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

RECEIVED
FEB 7 1949
BUREAU V. S.

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

7620 0071

# CERTIFICATE OF DEATH

161a Reg. Dist. No. 4

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Penna. COUNTY Bedford |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 1 Day | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hyndman, Pa. |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital | STREET ADDRESS (If rural, give location) ✓ |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) Baby Girl Shaffer | | | 4. DATE OF DEATH (Month) 1 (Day) 30 (Year) 1949 | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Baby | 8. DATE OF BIRTH 1/29/49 | 9. AGE last birthday yrs. | If under 1 year Months. Days; If under 24 hrs. Hours 20 Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Cumberland Maryland | | 12. CITIZEN OF WHAT COUNTRY? |
| 13. FATHER'S NAME Charles John Shaffer | | | 14. MOTHER'S MAIDEN NAME Mary Emma Shaffer | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Charles Shaffer | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause (a) | Pulmonary Atelectasis | 20 hrs. |
| Antecedent cause(s) | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) | | |
| (c) | | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from 1.29, 1949, to 1.30, 1949, that I last saw the deceased alive on 1.30, 1949, and that death occurred at 10 A m., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| John A. Topper | | Hyndman Pa | 1.30.49 |

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE 2/2/49 | NAME OF CEMETERY OR CREMATORY Hyndman | LOCATION (City, town, or county) (State) Hyndman, Pa |
| DATE REC'D BY LOCAL REG. Jan. 31, 1949 | REGISTRAR'S SIGNATURE Winter R. Frantz M.D. | 24. FUNERAL DIRECTOR Harvey H. Zeigler Harvey H. Zeigler | ADDRESS Hyndman, Pa. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 7 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

0072

2411 N. Charles Street, Baltimore

331

# CERTIFICATE OF DEATH

830a

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH
COUNTY: Allegany
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (In this place): all her life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 156 E. Main St.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 156 E. Main St.

3. NAME OF DECEASED (Type or Print): (First) Caroline (Middle) Kemmerer (Last) Shaffer

4. DATE OF DEATH: (Month) Jan. (Day) 18 (Year) 1949

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 11-17-60

9. AGE last birthday: 88 yrs. If under 1 year: Months. If under 24 hrs.: Days, Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Frostburg, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry B. Shaffer

14. MOTHER'S MAIDEN NAME: Louisa Kemmerer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT: Mrs. Rae Van Ormer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage, recurrent Jan. '46 and 3 Dec. 48

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c) Generalized arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan., 1946, to 18 Jan., 1949, that I last saw the deceased alive on 16 Jan., 1949, and that death occurred at 8:45 P.M. m., from the causes and on the date stated above.

SIGNATURE: W. Alfred Van Ormer, M.D. (Degree or title) ADDRESS: Cumberland, Md. DATE SIGNED: 18 Jan. 49

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: 1-20-49

NAME OF CEMETERY OR CREMATORY: Allegany

LOCATION (City, town, or county) (State): Frostburg-Alleg-Md.

DATE REC'D BY LOCAL REG.: 1-19-49

REGISTRAR'S SIGNATURE: Mrs Stanley A. Roe

24. FUNERAL DIRECTOR: Joseph R. Durst ADDRESS

RECEIVED
JAN 21 1949
BUREAU V. S.

Within corporate limits

EVIDENCE FOR ADDITION OF IN ITEM #15 IS ON.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0073

230

# CERTIFICATE OF DEATH

562

Reg. Dist. No. 4

FILE NO. G 119 MAR 10 1949

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 6 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS 320 Waverly Terrace

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE West Virginia COUNTY Hampshire
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Levels, W. Va.
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) (First) SARAH (Middle) ALMEDIA (Last) SHANHOLTZER

4. DATE OF DEATH (Month) 1 (Day) 15 (Year) 1949

5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH June 13, 1860
9. AGE last birthday 88 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME John R. Durst
14. MOTHER'S MAIDEN NAME Elizabeth Roberson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT Mrs. Jessie Leasure

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Tumor of Colon

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) No operation or biopsy done [3/9/49 abc]

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH 5 x Months

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) Cumberland (COUNTY) Allegany (STATE) Md
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October, 1942 to January 15, 1949 that I last saw the deceased alive on January 14, 1949 and that death occurred at 12:45 a.m., from the causes and on the date stated above.

SIGNATURE J. Johnson Jr. (Degree or title) M.D. ADDRESS Cumberland Md DATE SIGNED 1-17-49

23. BURIAL, CREMATION REMOVAL (Specify) DATE Jan. 18 '49 NAME OF CEMETERY OR CREMATORY Methodist Ch. Cem. LOCATION (City, town, or county) Levels (State) W. Va.

DATE REC'D BY LOCAL REG. Jan. 17, 1949 REGISTRAR'S SIGNATURE W. L. Lantz, M.D.

24. FUNERAL DIRECTOR LOUIS STEIN, INC. Frank Stein Pres. ADDRESS Cumberland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 25 1949
BUREAU F. S.

Within corporate limits

0074

DR. GRACIE
Dr Deming

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

812.5

# CERTIFICATE OF DEATH

170 C

Reg. Dist. No. 4

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE W.VA. COUNTY HAMP. |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 2-HRS | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ROMNEY W.VA |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL | STREET ADDRESS (If rural, give location) Gravel Lane |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) (First) DOUGAL (Middle) Wm. (Last) SHANK | | | 4. DATE OF DEATH (Month) JAN. (Day) 20 (Year) 1949 | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED | 8. DATE OF BIRTH FEB. 14-1871 | 9. AGE last birthday 77 yrs. | If under 1 year Months. Days / If under 24 hrs. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer | | 10b. KIND OF BUSINESS OR INDUSTRY Town of Romney | 11. BIRTHPLACE (State or foreign country) W.VA | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. |
| 13. FATHER'S NAME JACOB SHANK | | | 14. MOTHER'S MAIDEN NAME ANN BARRETT | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If year, give war or dates of service) | | 16. SOCIAL SECURITY NO. 705-09-7176 | 17. INFORMANT son) Charles Shank | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral concussion & Shock — 3 hours

Antecedent cause(s) Hit by an Automobile

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Compound comminuted fracture lower right leg and left wrist, fractured nose, dislocated left shoulder

(c) 2 lacerations over left frontal bone.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒ |

| | | | | |
|---|---|---|---|---|
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) auto.accident | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 28 | (CITY OR TOWN) High St near Romney | (COUNTY) Hampshire | (STATE) W.Va. |
| TIME OF INJURY (Month) (Day) (Year) (Hour) Jan. 20/49 m. | INJURY OCCURRED While at Work ☒ Not While At work ☐ | HOW DID INJURY OCCUR? Hit by an automobile | | |

22. I hereby certify that I ~~attended~~ saw the deceased from 1-20, 1949, to ....., 19....., that I last saw the deceased alive on 1-20, 1949 and that death occurred at 12.40P.m., from the causes and on the date stated above.

Dead

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| H.V.Deming M.D. | H.V.Deming M.D. | Cumberland Md. | Jan. 20/49 |

| | | | | |
|---|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) BURIAL. | DATE Jan 23, 1949 | NAME OF CEMETERY OR CREMATORY Indian Mound | LOCATION (City, town, or county) Romney | (State) W.Va. |
| DATE REC'D BY LOCAL REG. Jan. 20, 1949 | REGISTRAR'S SIGNATURE W.R. Frantz M.D. | 24. FUNERAL DIRECTOR A°C°Ruckman | ADDRESS Romney, W°Va. | |

Deputy Medical Examiner Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 25 1949
BUREAU V. S.

0075

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

422.2

# CERTIFICATE OF DEATH

93d Reg. Dist. No. 6

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barton — LENGTH OF STAY (in this place) 78 years | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Barton |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS | STREET ADDRESS (If rural, give location) |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) (First) John (Middle) (Last) Shuhart | | | 4. DATE OF DEATH (Month) January (Day) 10 (Year) 1949 | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) wid. | 8. DATE OF BIRTH Sept 10, 1869 | 9. AGE last birthday 79 yrs. | If under 1 year Months. Days; If under 24 hrs. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mine Foreman retired | 10b. KIND OF BUSINESS OR INDUSTRY Coal Mine | 11. BIRTHPLACE (State or foreign country) Barton, Maryland | 12. CITIZEN OF WHAT COUNTRY? USA | | |
| 13. FATHER'S NAME Frederick Shuhart | | 14. MOTHER'S MAIDEN NAME Mary Burkett | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) | 16. SOCIAL SECURITY No. | 17. INFORMANT William Shuhart | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Chr. Myocarditis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from 1/9, 1949, to 1/10, 1949, that I last saw the deceased alive on 1/9, 1949, and that death occurred at ..... m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

R W Reeves, MD Westernport Md 1/12/49

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE Jan 12, 1948 | NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery | LOCATION (City, town, or county) (State) Moscow, Allegany, Md. |
| DATE REC'D BY LOCAL REG. Jan. 12, 1949 | REGISTRAR'S SIGNATURE [signature] MD | 24. FUNERAL DIRECTOR Ellsworth S. Boal, Westernport, Md. | ADDRESS |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 13 1949
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

0076

543

159

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 8 DAYS

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 628 LAING AVE. EXT.,
(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** BABY BOY SIRBAUGH

**3.(b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | SINGLE |

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) DECEMBER 24, 1948

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| | | 8 | ..... hrs. ..... min. |

9. Birthplace CUMBERLAND, MARYLAND
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name LEONARD SIRBAUGH

13. Birthplace WEST VIRGINIA

MOTHER — 14. Maiden name FRANCES PATTERSON

15. Birthplace WEST VIRGINIA Waynesboro, Pa.

16. Informant Lennard Sirbaugh

Address 628 E. Lang Ave. Ext.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 3, 1949 (month) (day) (year)

Cemetery or crematory Zion Memorial Cem.

Location Cumberland, Md.

18. Funeral director Scarpelli Funeral Home

Address Cumberland, Md.

19. Jan 3, 1949 (Date rec'd by registrar) W. L. Trautz, M. D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 1, 1949 at 11:40 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.... to Jan. 1, 1949

and that I last saw him alive on Jan. 1, 1949

| Immediate cause of death | DURATION |
|---|---|
| Premature | 33 wks |
| Due to Gastritis | 5 days |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Clayt. Durrett M. D. or other

Address Cumberland Date signed 1/2/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
JAN 12 1949
BUREAU V. S.

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS. A15

T

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0077

541.0
117b

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (in this place) 37 Yrs | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany Hospital | STREET ADDRESS (If rural, give location) 154 Frederick Street |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) Hubert | (Middle) Silfir | (Last) Smith | 4. DATE OF DEATH | (Month) January | (Day) 19 | (Year) 1949 |
| 5. SEX Male | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH March 25 1885 | 9. AGE last birthday 63 yrs. | If under 1 year Months 9 | Days 24 | If under 24 hrs. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baker | 10b. KIND OF BUSINESS OR INDUSTRY Baking Pies | 11. BIRTHPLACE (State or foreign country) Boonsboro, Maryland. | 12. CITIZEN OF WHAT COUNTRY? USA | | | | |
| 13. FATHER'S NAME Omar Smith | 14. MOTHER'S MAIDEN NAME Emma Houpt | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) | 16. SOCIAL SECURITY No. 214-07-5137 | 17. INFORMANT Mrs. Elizabeth Smith | | | | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Duodenal ulcer —

Antecedent cause(s) (b) Coronary heart disease —

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION 1/19/49 | 19b. MAJOR FINDINGS OF OPERATION Penetrating ulcer) duodenum c̄ obstruction | 20. AUTOPSY? Yes ☐ No ☒ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) | |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from 1/3, 1949, to 1/20, 1949, that I last saw the deceased alive on 1/20, 1949, and that death occurred at 0 m., from the causes and on the date stated above.

SIGNATURE John K Rozner MD (Degree or title) ADDRESS Cumberland Maryland DATE SIGNED 1/20/49

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE January 22 1949 | NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery | LOCATION (City, town, or county) Boonsboro (State) Maryland |
| DATE REC'D BY LOCAL REG. Jan. 21, 1949 | REGISTRAR'S SIGNATURE Winter R. Frantz, M.D. | 24. FUNERAL DIRECTOR William H. Kight, | ADDRESS Cumberland, Md |

RECEIVED
JAN 25 1949
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

0078

334
83a

Reg. Dist. No. 10

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

T

VS A15 9-45-15M

**1. PLACE OF DEATH:**

County Allegany

City or town Mt. Savage Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Calla Hill

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)

Street No. Calla Hill
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** John Smith

**3. (b) Social Security Number** none

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | white | married |

6.(b) Name of husband or wife Lydia C. Sigler Smith

6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) April 1-1874

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 9 | 2 | ...hrs. ...min. |

9. Birthplace Mt. Savage, Allegany, Md.
(Town, county, and state)

10. Usual occupation Retired brickworker

11. Industry or business Mt. Savage Brick Works

FATHER
12. Name Charles Smith
13. Birthplace Germany

MOTHER
14. Maiden name Mary Lynch
15. Birthplace Maryland

16. Informant Mrs. Mary Keel,
Address Mt. Savage, Md.

17. Burial Date thereof Jan. 8, 1949
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St. Patrick's Cemetery,
Location Mt. Savage, Md.

18. Funeral director J. R. Durst,
Address Frostburg, Md.

19 Jan. 7 1949 Vernia McDermott
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 4 19 49 at 3.05 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ...19..., to ...19...
and that I last saw him alive Dead Jan. 4 19 49

| Immediate cause of death | DURATION |
|---|---|
| Apoplexy | about 2 days. |
| Due to arteriosclerosis | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address Cumberland Md. Date signed 1-6-49

RECEIVED
JAN 10 1949
BUREAU V. S.

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

334

0079

# CERTIFICATE OF DEATH 83a

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany
STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 615 Piedmont Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md.
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 615 Piedmont Ave.

3. NAME OF DECEASED (Type or Print): (First) Grace (Middle) L. (Last) Snyder

4. DATE OF DEATH: (Month) Jan. (Day) 13 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 4-13-1881

9. AGE last birthday: 67 yrs. If under 1 year: Months. Days. If under 24 hrs.: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Centerville Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel W.Snyder

14. MOTHER'S MAIDEN NAME: Sara Boor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: brother) Grover Snyder

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Apoplexy — Interval between onset and death: about 8 hours.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension due to arteriosclerosis.

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan.13, 1949, to ....., 19....., that I last saw the deceased alive on Jan.13, 1949, and that death occurred at 10.20 A.m., from the causes and on the date stated above.

SIGNATURE: H.V.Deming M.D. (Degree or title)

ADDRESS: 125 Bedford St. Cumberland Md.

DATE SIGNED: Jan.13-49

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE: 1/15/49

NAME OF CEMETERY OR CREMATORY: Rose Hill

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Jan. 15 1949

REGISTRAR'S SIGNATURE: Winter R. Fauntz, M.D.

24. FUNERAL DIRECTOR: Charles L. George

ADDRESS: Cumberland, Md.

VS. A15

RECEIVED
JAN 18 1949
BUREAU V. S.

0080

CHANGE OF AGE SHOWN ON:

422.1

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

FILM No. G 118 JAN 19 1949 **CERTIFICATE OF DEATH** 1310

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS: A15

**1. PLACE OF DEATH**
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
MARYLAND — LENGTH OF STAY (in this place): about 35 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 158 Mechanic St.

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Maryland
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 158 Mechanic Street.

**3. NAME OF DECEASED** (Type or Print): (First) Carmella (Middle) (Last) Spalla

**4. DATE OF DEATH**: (Month) January (Day) 9th (Year) 1949

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED** (Specify): Widowed

**8. DATE OF BIRTH**: June 16th, 1872

**9. AGE** last birthday: 76 yrs. | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): House wife

**10b. KIND OF BUSINESS OR INDUSTRY**:

**11. BIRTHPLACE** (State or foreign country): Italy

**12. CITIZEN OF WHAT COUNTRY?**:

**13. FATHER'S NAME**: Unknown

**14. MOTHER'S MAIDEN NAME**: Unknown

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If year, give war or dates of service):

**16. SOCIAL SECURITY NO.**:

**17. INFORMANT**: Samuel Spalla

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Chronic myocarditis | 3 yrs. |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Chronic syphilis | 2 yrs. |
| | (c) arterio-sclerosis. | 10 yrs. |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Senility.

**19a. DATE OF OPERATION**: none

**19b. MAJOR FINDINGS OF OPERATION**:

**20. AUTOPSY?** Yes ☐ No ☑

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify): /

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1, 1946, to Jan. 9, 1949, that I last saw the deceased alive on Jan. 9, 1949, and that death occurred at 1 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

H. E. Diehl, M.D. | Frostburg, Md. | 1-11-49.

**23. BURIAL, CREMATION, REMOVAL** (Specify): Burial | DATE: 1/12/49 | NAME OF CEMETERY OR CREMATORY: St. Michaels Cemetery | LOCATION (City, town, or county) (State): Frostburg Md.

DATE REC'D BY LOCAL REG.: 1-11-49 | REGISTRAR'S SIGNATURE: Mrs. Nancy H. Lee | 24. FUNERAL DIRECTOR: Jacob Hafer | ADDRESS: Frostburg, Maryland

RECEIVED
JAN 13 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore 776

# CERTIFICATE OF DEATH 159

0081

Reg. Dist. No. 9

M

(The correct age is especially important.)

MARGIN RESERVED FOR BINDING. Supply every item of information carefully. PLEASE WRITE PLAINLY, WITH UNFADING INK. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY Alleg.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN FROSTBURG
STREET ADDRESS (If rural give location) 144 W. MAIN ST.

3. NAME OF DECEASED (Type or Print): (First) Baby (Middle) Raymond (Last) Stains
4. DATE OF DEATH: (Month) Jan (Day) 20 (Year) 1949

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Jan 20 1949
9. AGE last birthday: yrs. — If under 1 year: Months — Days: 6 — If under 24 hrs.: Hours — Min.: 45

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Frostburg Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Glenn Eugene Stains
14. MOTHER'S MAIDEN NAME: Elizabeth Starkey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If year, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Elizabeth Stains

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Prematurity 5 mo — 6 hs 45 mn

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b)

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 20, 1949, to Jan 20, 1949, that I last saw the deceased alive on Jan 20, 1949, and that death occurred at 7:10 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
W. M. McLane M.D. Frostburg Md 1-22-49

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE: 1-20-49
NAME OF CEMETERY OR CREMATORY: Allegany Cemetery
LOCATION (City, town, or county) (State): Frostburg Md.

DATE REC'D BY LOCAL REG.: 1-21-49
REGISTRAR'S SIGNATURE: Mrs Nancy N. Roe
24. FUNERAL DIRECTOR: Joseph R. Hurst
ADDRESS: Frostburg Md.

VS. A15

RECEIVED
JAN 25 1949
BUREAU V. S.

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 420.1 0682

## CERTIFICATE OF DEATH 940 Reg. Dist. No. 4

**1. PLACE OF DEATH:**
County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Enroute to Memorial Hosp from home
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 514 Beall St.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** O. Otis Sterne

**3.(b) Social Security Number** 705-07-6586

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | white | married |

6.(b) Name of husband or wife Daisy Ayersman Sterne
6.(c) If alive, give age 56 years
7. Birth date of deceased (mo., day, yr.) Oct. 28- 1886

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 2 | 6 | hrs. min. |

9. Birthplace Bearsville W.Va. (Town, county, and state)
10. Usual occupation Road Foreman
11. Industry or business B&O°R.Ry.

FATHER
12. Name Jacob Sterne
13. Birthplace W.Va.

MOTHER
14. Maiden name Matelda Fox
15. Birthplace W.Va.

16. Informant Mrs. Otis Sterne
Address 514 Beall St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 7 1949 (month) (day) (year)
Cemetery or crematory HillCrest Burial Park
Location Cumberland, Md.

18. Funeral director H. Wayne George
Address Cumberland, Md.

19. Jan. 7 1949 (Date rec'd by registrar) W.R. Beasley M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Jan. 4 1949 at 12.50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw him alive Dead Jan. 4 1949

| Immediate cause of death | DURATION |
|---|---|
| Coronary occlusion | at once |
| Due to coronary sclerosis, also | about 2 |
| old myocardial aneurysm, left | years. |
| side of heart, hydrothorax | |
| bilateral & anasarca. | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V.Deming M.D. H.V. Deming M.D.
M. D. or other
Address Cumberland Md. Date signed 1-4-49

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
JAN 12 1949
BUREAU V. S.

Dr Moseley
0083

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

422.2
93d

Reg. Dist. No. 10

| | |
|---|---|
| 1. PLACE OF DEATH · COUNTY: Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED · STATE: Maryland COUNTY: Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage — LENGTH OF STAY (in this place): 30 yrs. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Mt. Savage |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: — | STREET ADDRESS (If rural, give location): — |

3. NAME OF DECEASED (Type or Print): (First) Catherine (Middle) Elizabeth (Last) Stevens

4. DATE OF DEATH: (Month) Jan. (Day) 21, (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: 6-22-1860

9. AGE last birthday: 88 yrs. — If under 1 year: Months. Days — If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Frostburg Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Hager

14. MOTHER'S MAIDEN NAME: Christina Koppenstein

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mrs. Effie Pickrell

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) PULMONARY OEDEMA. | 2 weeks. |
| Antecedent cause(s) | | |
| Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) MYOCARDIAL DEGENERATION. | |
| | (c) | |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. ADVANCED AGE

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify): — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1944, to January 20, 1949, that I last saw the deceased alive on January 20, 1949, and that death occurred at 5:00 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title): William E. Moseley, M.D. — ADDRESS: — DATE SIGNED: January 21st 1949

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE: 1-23-49 — NAME OF CEMETERY OR CREMATORY: Allegany Cemetery — LOCATION (City, town, or county): Frostburg (State): Md.

DATE REC'D BY LOCAL REG.: Jan 22-49 — REGISTRAR'S SIGNATURE: Veronica McDermott

24. FUNERAL DIRECTOR: J. R. Durst — ADDRESS: Frostburg, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 27 1949
BUREAU T. S.

0684

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

422.1 / 93d

Reg. Dist. No. 6

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY Allegany MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport — LENGTH OF STAY (in this place) 67 yrs. | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Front Street | STREET ADDRESS (If rural, give location) Front Street |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) ROSE | (Middle) WILSON | (Last) STOWELL | 4. DATE OF DEATH | (Month) January (Day) 24 (Year) 1949 |
| 5. SEX Female | 6. COLOR OR RACE White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married | 8. DATE OF BIRTH June 29, 1874 | 9. AGE last birthday 74 yrs. | If under 1 year Months / Days; If under 24 hrs. Hours / Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | 10b. KIND OF BUSINESS OR INDUSTRY Home | 11. BIRTHPLACE (State or foreign country) Scotland | 12. CITIZEN OF WHAT COUNTRY? Yes U.S. | | |
| 13. FATHER'S NAME Thomas Wilson | 14. MOTHER'S MAIDEN NAME Alice Murphy | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service) — | 16. SOCIAL SECURITY NO. — | 17. INFORMANT Mrs. May Adams | | | |

## 18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Chronic Myocarditis | 1 year |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Arteriosclerosis | 5 years |
| | (c) Cholecystitis | 1 year |

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. ---

| | | |
|---|---|---|
| 19a. DATE OF OPERATION — | 19b. MAJOR FINDINGS OF OPERATION --- | 20. AUTOPSY? Yes ☐ No ☒ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) — | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — | (CITY OR TOWN) — (COUNTY) (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) — m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? — |

22. I hereby certify that I attended the deceased from June 1, 1944, to January 24 1949, that I last saw the deceased alive on January 24, 1949, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

| SIGNATURE | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| F. E. Berry | M.D. | Piedmont, W. Va. | 1/25/49 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Jan. 28, 1949 | St. Peters Cemetery, Westernport, Maryland | |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Jan. 26, 1949 | [illegible] | W. Harold Fredlock, Jr., | Piedmont, W. Va. |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

I

T

RECEIVED
JAN 27 1949
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

420.1 qua

0685

Reg. Dist. No. 10

**1. PLACE OF DEATH:**

County: Allegany

City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: 1st World War

**3.(a) FULL NAME:** Robert R. Sween

**3.(b) Social Security Number:** 705-05-4521

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed; or divorced |
|---|---|---|
| M | W | married |

6.(b) Name of husband or wife: Katherine Sween

6.(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): Sept. 15-1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 3 | 18 | ...hrs. ...min. |

9. Birthplace: Mt. Savage - alleg. Md.
(Town, county, and state)

10. Usual occupation: boiler Maker

11. Industry or business: B & O R.R.

FATHER
12. Name: John Sweeney
13. Birthplace: Wellersburg, Pa.

MOTHER
14. Maiden name: Christina Hergott
15. Birthplace: md

16. Informant: Mrs Robt Sween
Address: Mt. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-4-49 (month) (day) (year)

Cemetery or crematory: St. George

Location: Mt. Savage, Md.

18. Funeral director: Joseph R. Hurst

Address: Frostburg, Md.

19. JAN 4 1949 (Date rec'd by registrar) Veronica M. Dennis Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: JANUARY - 2ND 1949 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JULY 1ST. 1948 to JAN. 2ND 1949 and that I last saw him alive on DECEMBER 30th 1948

| Immediate cause of death | DURATION |
|---|---|
| CORONARY THROMBOSIS | |
| Due to ARTERIO-SCLEROSIS | Several years. |
| Due to | |
| Other conditions VASCULAR HYPERTENSION | several years. |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: William E. Moseley M.D.
M. D. or other

Address: Mt Savage Md. Date signed 1-2-1949

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
JAN 6 1949
BUREAU V. S.

Within corporate limits DR. FAW

0086

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

570.5
93d

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MARYLAND

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY Allegany COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 218 PARK STREET

3. NAME OF DECEASED (Type or Print) (First) AMANDA (Middle) E. (Last) TAYLOR

4. DATE OF DEATH (Month) January (Day) 26 (Year) 1949

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH NOV. 11, 1874

9. AGE last birthday 74 yrs. If under 1 year: Months 2 Days 15 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Selbysport, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME JEFFERSON FRAZEE

14. MOTHER'S MAIDEN NAME EMMA BOLLIN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY No. None

17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 6 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Intestinal Obstruction cause undetermined — 10 days

(c) Arterio-sclerotic cardio-vascular disease ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION JAN. 22, 1949

19b. MAJOR FINDINGS OF OPERATION Intestinal obstruction - Splenic flexure cause undetermined — Ceostomy for release

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE) Cum

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 22, 1949, to Jan 26, 1949, that I last saw the deceased alive on Jan 26, 1949, and that death occurred at 1:10 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Wylie M Faw Jr MD. ADDRESS 5 Washington St. Cumberland Md DATE SIGNED Jan 26, 49

23. BURIAL, CREMATION REMOVAL (Specify) Removal and burial DATE Jan. 29, 1949 NAME OF CEMETERY OR CREMATORY Terra Alta Cemetery LOCATION (City, town, or county) (State) Terra Alta, West Virginia

DATE REC'D BY LOCAL REG. Jan. 29, 1949 REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR P. A. Watson ADDRESS Terra Alta, W.Va.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 1 1949
BUREAU V. S.

Within corporate limits

DR. DURRETT

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

026
30

0087

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 yrs.

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 129 DAYS

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 601 QUEBECK STREET
(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME**
JAMES WATSON TRUE

**3.(b) Social Security Number**
705-09-1842

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | MARRIED |

6.(b) Name of husband or wife MAE BELLE WILSON

6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) SEPTEMBER 17 1883

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 65 | 3 | 15 | hrs. min. |

9. Birthplace PENNA.
(Town, county, and state)

10. Usual occupation Engineer

11. Industry or business B & O Ry.

FATHER
12. Name MARTIN TRUE
13. Birthplace Pa

MOTHER
14. Maiden name Elizabeth JANE Hyles
15. Birthplace Pa.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 5 '49 (month) (day) (year)

Cemetery or crematory Hillcrest Cem.

Location Cumberland

18. Funeral director Louis Stein Inc.
Address Cumberland

19. Jan. 5, 1949 (Date rec'd by registrar) W.R. Frantz, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH JANUARY 2 1949 at 11:40AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to Jan. 2, 1949 and that I last saw him alive on 19

| Immediate cause of death | DURATION |
|---|---|
| Uraemia | 3 mos |
| myocarditis | 6 mos |
| Due to Cerebro Spinal Lues | 3 yrs |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clay E. Furnero M. D. or other

Address Cumberland Date signed 1/3/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

RECEIVED
JAN. 12 1949
BUREAU V. S.

Witham corporate [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0088

# CERTIFICATE OF DEATH

Reg. Dist. No. 4

EVIDENCE FOR CHANGE OF AGE IS ON: FILM No. G 118 FEB -2 1949

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: ALLEGANY — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 2 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: WEST VIRGINIA — COUNTY: MINERAL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: WILEY FORD
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): (First) WILBUR (Middle) I. ? (Last) TYSINGER

4. DATE OF DEATH: (Month) JANUARY (Day) 17 (Year) 1949

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWER

8. DATE OF BIRTH: MAR. 14, 1885

9. AGE last birthday: ~~84~~ 63 yrs. If under 1 year: Months. 10 Days 3 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CARMAN HELPER

10b. KIND OF BUSINESS OR INDUSTRY: B.&O.R.R. RAILROAD

11. BIRTHPLACE (State or foreign country): VIRGINIA U.S.A.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: CHARLES TYSINGER

14. MOTHER'S MAIDEN NAME: VIRGINIA URT

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If year, give war or dates of service):

16. SOCIAL SECURITY NO.: 705-09-9521

17. INFORMANT: MEMORIAL HOSPITAL

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial Infarct — Interval between onset and death: 2

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary occlusion — days

(c) Thrombous of the Circle of Willis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

Deputy Medical [illegible]

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I ~~attended~~ saw the deceased from Jan 17, 1949, to ~~19~~, that I last saw the deceased alive on Jan 17, 1949, and that death occurred at m., from the causes and on the date stated above.

SIGNATURE H.V. Deming M.D. (Degree or title) ADDRESS 125 Bedford St Cumberland, Md DATE SIGNED 1-18-49

H. V. Deming M.D.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 1/20/49 — NAME OF CEMETERY OR CREMATORY: Hill Crest Cemetery — LOCATION (City, town, or county) (State): Cumberland, Maryland.

DATE REC'D BY LOCAL REG.: Jan. 20, 1949 — REGISTRAR'S SIGNATURE: Winter R. Fautz. M.D.

24. FUNERAL DIRECTOR — ADDRESS: William H. Kight, Cumberland, Md

Deputy Medical Examiner Allegany Co

DR. DURRETT

VS. A15

RECEIVED
JAN 25 1949
BUREAU V. S.

Within corporate limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

420.1

0089

# CERTIFICATE OF DEATH 93d

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

| | |
|---|---|
| 1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md.; COUNTY: Allegany |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (in this place): 40 years | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS: 225 Glenn St. | STREET ADDRESS (If rural, give location): 225 Glenn St. |

| 3. NAME OF DECEASED (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| William | Harley | Vandegrift | Jan. | 21 | 1949 |

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| male | white | married | June25-1884 | 64 yrs. | 6 | 26 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Carpenter | Building houses | Romney W.Va. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William Vandegrift | Margaret Haines |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| No | 214-05-5896 | Mrs. Mary(Smith) Vandegrift |

## 18. MEDICAL CERTIFICATION

| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| Immediate cause | (a) Myocardial Infarction | 30 minutes |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last | (b) Coronary occlusion | 30 minutes |
| | (c) Arteriosclerosis, cardio-vascular disease | ? |

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| none | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) | (Day) | (Year) | (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|---|---|---|
| | | | | | |

22. I hereby certify that I ~~attended~~ saw the deceased ~~from~~ Jan. 21, 1949, to ---------, 19....., that I last saw the deceased alive on Jan. 21, 1949, and that death occurred at 10.45 A.m., from the causes and on the date stated above.

Dead

| SIGNATURE. | (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| H.V. Deming M.D. | Deputy Medical | Cumberland Md. | Jan. 21-1949 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Jan. 23 1949 | Ebenezer Cemetery | Romney W.Va. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| Jan. 23, 1949 | Minter L. Fantz, M.D. | William H. Kight, Cumberland | Md. |

Deputy Medical

VS. A15

RECEIVED
JAN 25 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

420.1 940 0090

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH**
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): all his life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 22 Centennial St.

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural, give location): 22 Centennial St.

**3. NAME OF DECEASED** (Type or Print): (First) Christopher (Middle) J. (Last) Walbert

**4. DATE OF DEATH**: (Month) Jan. (Day) 18 (Year) 1949

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months. Days | If under 24 hrs.: Hours Min. |
|---|---|---|---|---|---|---|
| male | white | Married | 10-23-93 | 55 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Miner | coal mines | Frostburg, Maryland | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Jacob Walbert | |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|---|
| Yes | 1st World War | 216-07-9098 | Mrs. Clara Walbert |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Coronary Insufficiency, right

Antecedent cause(s) (b) Arteriosclerosis — several years

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary edema and Congestion — about 2 weeks

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☒ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I ~~attended~~ saw the deceased from Jan. 18, 1949 to ---------, 19---, that I last saw the deceased Dead alive on Jan. 18, 1949, and that death occurred at about 6 A. m., from the causes and on the date stated above.

| SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED |
|---|---|---|
| Deputy Medical Examiner - Allegany Co.<br>H.V. Deming M.D. H.V. Deming MD | Cumberland Md. | Jan. 18-49 |

| 23. BURIAL, CREMATION REMOVAL (Specify) | DATE | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1-20-49 | Zion Evangelical | Frostburg-alleg. Md. |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1-19-49 | Mrs. Sallie V. Roe<br>Deputy Medical Examiner - Allegany Co. | Joseph R. Dust | |

RECEIVED
JAN 21 1949
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

0691

903,5
186a

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; STREET ADDRESS (If rural, give location) 17 Mt. Pleasant

3. NAME OF DECEASED (Type or Print): (First) MARY (Middle) MARGARET (Last) Weimer

4. DATE OF DEATH: (Month) JAN. (Day) 9 (Year) 1949

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: 8-3-1904

9. AGE last birthday: 44 yrs. If under 1 year: Months. Days. If under 24 hrs: Hours. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William CAPEL

14. MOTHER'S MAIDEN NAME: BERNADETTE McDONALD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Vincent Weimer

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Tetanus — Interval between onset and death: 5 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Confused laceration left knee — 16 days

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident; PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: Street; (CITY OR TOWN): Frostburg; (COUNTY): Allegany; (STATE): Maryland

TIME OF INJURY (Month) (Day) (Year) (Hour): December 25 1948 11 AM m.; INJURY OCCURRED While at Work ☐ Not While At work ☑

HOW DID INJURY OCCUR? Fell while crossing Street

22. I hereby certify that I attended the deceased from 1/6, 1949, to 1/9, 1949, that I last saw the deceased alive on 1/9, 1949, and that death occurred at 12 30 P m., from the causes and on the date stated above.

SIGNATURE Hilda Jane Walthy (Degree or title) M.D ADDRESS Frostburg, Md DATE SIGNED 1/9/49

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL; DATE: JAN. 12 '49; NAME OF CEMETERY OR CREMATORY: St. Ann's Cemetery; LOCATION (City, town, or county): Frostburg (RURAL); (State): Md.

DATE REC'D BY LOCAL REG.: 1-10-49; REGISTRAR'S SIGNATURE: Mrs. Hanley K. Roe

24. FUNERAL DIRECTOR: J. R. Durst; ADDRESS

VS. A15

RECEIVED
JAN 12 1949
BUREAU V. S.

Within corporate limits

0692

Rees

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

331

# CERTIFICATE OF DEATH

83a Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 523 Valley St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 523 Valley St.

3. NAME OF DECEASED (Type or Print) (First) Effie (Middle) Ludora (Last) Whitman
4. DATE OF DEATH (Month) Jan (Day) 28, (Year) 1949
5. SEX Female
6. COLOR OR RACE White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH Oct 25 1875
9. AGE last birthday 73 yrs. If under 1 year Months. Days If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Cumberland Md
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Frederick Frost
14. MOTHER'S MAIDEN NAME Drunosky
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)
16. SOCIAL SECURITY No. None
17. INFORMANT Frank W. Whitman

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Cerebral Hemorrhage 1 hr

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerosis Unknown

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURRED While at Work ☐ Not While At work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 28, 1949 to Jan 28, 1949, that I last saw the deceased alive on Jan 28, 1949, and that death occurred at 4:15 m., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or title) ADDRESS 4 & 4 Decatur St Cumberland DATE SIGNED 1/49

23. BURIAL, CREMATION REMOVAL (Specify) Burial
DATE Jan 31, 1949
NAME OF CEMETERY OR CREMATORY Greenmount Cem.
LOCATION (City, town, or county) Cumberland (State) Md

DATE REC'D BY LOCAL REG. Jan. 31, 1949
REGISTRAR'S SIGNATURE Winter R. Lantz, M.D.
24. FUNERAL DIRECTOR John J. Hafer, ADDRESS Cumberland Md

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

RECEIVED
FEB 7 1949
BUREAU V. S.